Los Angeles County Commission on Disabilities

Celebrating 39 Years of Leadership & Advocacy

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November XX, 2014

TO: The Honorable Don Knabe, Chairman
The Honorable Gloria Molina
The Honorable Mark Ridley-Thomas
The Honorable Zev Yaroslavsky
The Honorable Michael D. Antonovich

FROM: Janet A. Neal, President
Commission on Disabilities

SUBJECT: **SUPPORT OF COMMUNITY-BASED SERVICES**

The Commission is writing this letter to inform you of the more than 80,000 residents of Los Angeles County who are living with developmental disabilities, their families and the scores of community-based organizations upon whom they depend for vital services and support.

The basic human and social services safety net enabling individuals with these severe and life-long disabilities to live and function within our community is provided through the State of California's Department of Developmental Services (DDS). By law (Welfare and Institutions Code 4500), the DDS is required to develop and administer a coordinated network of independent community-based service providers, assuring that effective services are available to these individuals wherever they live in our State. These are the services that have allowed California to depopulate its large State institutions moving instead to a far more humane and enlightened system of community-based care for its citizens with developmental disabilities.

Unfortunately, after more than 20 years of state cost cutting and inattention, this system is now showing signs of severe strain and disintegration. If these problems are left unchecked, it is likely that vital services will disappear, leaving the welfare of many of our County's most vulnerable residents at great risk. As far back as 1998, the State Auditor drew attention to these mounting problems and the State Legislature in the Budget Act of 1998 directed the DDS to implement a reimbursement mechanism that would assure sustainability of these vital services. The State has yet to implement any such reforms (documentation attached).

With this letter the Commission asks the Board of Supervisors to communicate its deep concern for the welfare of its developmentally disabled residents to the Governor Edmund G. Brown, Jr. Please urge the Governor to: 1) address the immediate needs of its community-based services in the State Budget for FY 2015, and 2) without further delay complete the implementation of a reimbursement system that will assure the sustainability of these services in future years.

JAN:edj

Enclosures

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California State Auditor

BUREAU OF STATE AUDITS

Department of Developmental Services:

Without Sufficient State Funding, It Cannot Furnish Optimal Services to Developmentally Disabled Adults

October 1999
99112

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CALIFORNIA STATE AUDITOR

KURT R. SJOBERG
STATE AUDITOR

MARIANNE P. EVASHENK
CHIEF DEPUTY STATE AUDITOR

October 20, 1999 99112

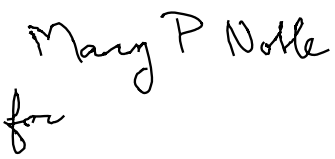
The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the ability of the State of California's 78,000 adults with developmental disabilities (consumers) to receive optimal services from organizations in the community (providers) and the statewide network of 21 independent, nonprofit regional centers.

This report concludes that although the State's service delivery system was designed to provide optimal services to consumers, its success has been undermined by insufficient state funding and budget cuts. The providers we surveyed unequivocally agree that their inability to compete for direct care staff—those individuals who work directly with the consumers—and receiving insufficient state financial support are the primary obstacles to consistently delivering quality services. Providers report that most of their direct care staff, who earn an average of $8.89 per hour, remain on the job barely two years. It takes providers almost three months to replace these staff, thus creating disruptions in services and impeding continuity for the consumers. Regional centers also report similar delays in replacing their case managers who leave, causing consumers to lose contact with the person who is key to ensuring that they get their services. The Department of Developmental Services is taking some steps to improve the system. However, until the State commits to ensuring that sufficient funding is available for this program, consumers will continue to receive less-than-optimal services to facilitate their inclusion into the community.

Respectfully submitted,



KURT R. SJOBERG
State Auditor

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SUMMARY

Audit Highlights . . .

Our review of the Department of Developmental Services' (department) program for adults with disabilities reveals that direct care staff:

- ☑ *Earn an average of $8.89 per hour with fewer than 40 percent offered benefits such as health insurance or sick leave.*
- ☑ *Remain on the job not quite two years.*
- ☑ *Have an average turnover rate of 50 percent.*

Regional center case managers, providing the primary contact for ensuring services to these adults:

- ☑ *Earn an average of $17.50 per hour, 6 percent less than case managers in public and private businesses performing comparable duties.*
- ☑ *Remain on the job at least three years.*
- ☑ *Have a much lower turnover rate (14 percent) than direct care staff.*

Furthermore, our review found that the State has not appropriated sufficient funds to ensure that consumers receive optimal services.

RESULTS IN BRIEF

The Lanterman Developmental Disabilities Services Act (Lanterman Act) charges the State of California with overseeing services to assist all people with developmental disabilities (consumers) who wish to become a part of their communities. The Department of Developmental Services (department) uses a statewide network of 21 independent, nonprofit regional centers to coordinate these consumer services. Case managers at the centers assist consumers with individual program plans that outline all services consumers need to achieve their desired goals, ranging from transportation to training in job or life skills. To carry out the plans, regional centers contract with organizations (providers) in the community for certain services. The providers hire the direct care staff that work directly with consumers.

The State's system was designed to provide optimal service to consumers, but its success has been undermined by insufficient state funding and more than $106 million in budget cuts over a four-year period. The cuts occurred in the early 1990s and have not been fully restored, preventing the program from paying rates that reflect current economic conditions. Some providers did not receive any rate increases for more than six years. Only within the last year has the State granted $33 million to increase rates for these providers.

Insufficient state funding figures prominently as one of the major obstacles that program providers report in delivering quality services to consumers. Providers we surveyed unequivocally agree that funding keeps them from effectively competing for qualified direct care staff in California's flourishing job market. On average, direct care staff make $8.89 per hour. Fewer than 40 percent of the providers we surveyed offer benefits such as health insurance or sick leave. Providers find it difficult to attract candidates who could easily make the same or more money in equivalent positions with seemingly less stressful duties. Once providers hire direct care staff, they find it difficult to retain them: The average turnover rate for the last approximately 3.5 years was 50 percent, with most staff staying not quite two years.

Lengthy job vacancies create further disruptions in services. Providers need almost three months to fill openings and new direct care staff require time to get to know the consumers and learn their needs. Continually establishing new relationships affects consumers as well; they regularly experience the loss of continuity in their services as well as the personal loss of familiar staff who assist them.

The regional centers we surveyed also report difficulties with hiring and retaining staff. The turnover rate for case managers was fairly low (14 percent) during the same period, and they remained in their positions three years or longer. However, these positions also have fairly lengthy vacancy rates. It takes about 2.5 months to fill the openings. The regional centers cite numerous causes for these delays, such as an unavailability of qualified personnel, the stressful nature of the work, and their inability to offer competitive salaries and career opportunities. Lengthy vacancies create further stress for the remaining staff, who must handle increased caseloads. The regional centers do not have sufficient state funding to hire enough case managers to relieve other case managers' loads. As a result, the managers are squeezed for enough time to properly address the consumers' needs, which can delay or disrupt services.

We found that direct care staff in the developmental centers serve a different, more profoundly needy population, so their duties generally do not compare to the provider's direct care staff. Therefore, we compared the wages of direct care staff and case managers under contracts with the department to those in comparable programs, specifically providers working for the Departments of Aging and Rehabilitation. Direct care staff under all three departments earn an average wage ranging between $8.60 and $9.10 per hour. Case managers under the department earn an average of $17.50 per hour, while those under the Department of Aging make about 40 cents per hour less. However, our survey indicates that there is no correlation between wages and required experience for either position among the departments. We further found that case workers in public and private businesses performing comparable duties earn an average of $18.55 per hour, more than case managers for the two state departments.

Although we found it difficult to assess the direct impact that insufficient state funding and staffing difficulties have on individual consumers, our survey indicates that the State must improve this delivery system so consumers can receive

consistent services, maintain long-term relationships with direct care staff, and thus integrate successfully with their communities. The department is taking some steps to improve the existing system, such as examining ways to revise the method it uses to pay certain providers and engaging a consultant to evaluate its budget process for the regional centers. However, until the State commits to ensuring that sufficient funding is available for this program, it will never be able to realize the spirit of the Lanterman Act.

RECOMMENDATIONS

To ensure that consumers receive optimal services from the State in accordance with the Lanterman Act, the Legislature must take interim measures to align state funding with program costs until the department improves the existing service delivery system and implements a new budget process for the regional centers. Any additional funding should be earmarked specifically for increasing compensation for qualified direct care staff and reducing the caseloads for regional center case managers.

To ensure that providers continuously receive funding that reflects current economic conditions, thus allowing them to compete for qualified direct care staff, the department should expedite the completion of its service delivery reform efforts.

Finally, to effectively oversee consumer plans at the regional centers, the department should carefully consider its consultants' recommendations for the regional center budget process and implement those it deems beneficial as quickly as possible.

AGENCY COMMENTS

The department shares the concerns expressed in our report regarding the importance of ensuring the availability of qualified and competent direct care staff for all programs serving persons with developmental disabilities. However, it believes that expenditure decisions should be made in the context of the needs of its service delivery system as a whole. ■

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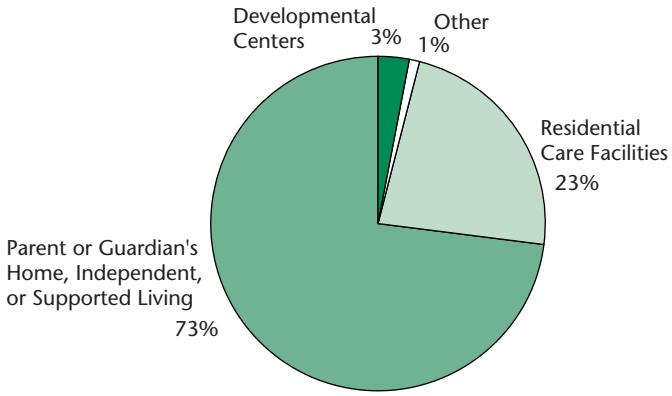
INTRODUCTION

BACKGROUND

The Lanterman Developmental Disabilities Services Act (Lanterman Act) charges the State with establishing a service delivery system for all people with developmental disabilities (consumers) to facilitate their integration into the community. Consumers with mental retardation, cerebral palsy, epilepsy, autism, or other conditions requiring similar treatment as for mental retardation can receive services for life as long as their disability begins before their 18th birthday. The Department of Developmental Services (department) administers the service delivery system. About 133,000 consumers receive services through the department. Most (73 percent) live at home with a parent or guardian, live independently and receive services as needed, or have a supported-living arrangement and receive continuous services. About 23 percent live in 24-hour residential care facilities, while only 3 percent reside in state-operated developmental centers. Figure 1 indicates what percentage of consumers live in each type of residence.

FIGURE 1

Department's Consumer Population Served by Resident Type as of June 30, 1999



Source: Department of Developmental Services' June 30, 1999, Report on Statewide Consumers by Age, Group, and Residence Type.

THE STATE'S SERVICE DELIVERY SYSTEM

In fiscal year 1999-2000, the State expects to spend more than $2 billion on its two primary programs for consumers: community services and developmental centers. To administer the community services program, the department contracts with a statewide network of 21 independent, nonprofit regional centers. The regional centers in turn assess and determine whether consumers should enter a developmental center or remain in the community. If the consumers remain in the community, the centers' case managers work with them, their families, and their advocates to choose the services that will best meet the consumers' needs and to develop an individual program plan. Figure 2 illustrates the process that regional centers use to ensure that consumers receive services under its community services program.

Few Consumers Live in Developmental Centers

The State operates five developmental centers, which provide 24-hour care and supervision to consumers. Residents of these facilities have greater medical and behavioral problems than do those living in the community. Of 3,700 residents living in developmental centers as of June 30, 1999, 67 percent have profound retardation, 70 percent have major medical problems, and more than 40 percent are frequently violent. To meet the residents' needs, the developmental centers use staff who are primarily psychiatric technicians and nurses.

Similar to the Lanterman Act, a 1993 lawsuit settlement, known as the Coffelt Settlement, calls for the State to help residents of developmental centers to integrate into their communities. As a result of this settlement, more than 2,300 consumers who have left the centers are now served by the community services program.

Services Available Through the Community Services Program

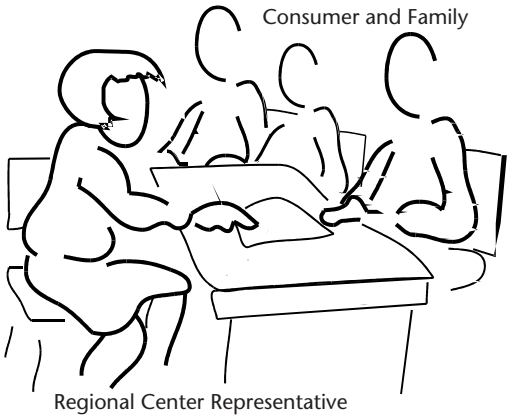
The regional centers' case managers are the primary contact for consumers in the community services program. They ensure that consumers receive the services outlined in their individual plans. Many services are available to consumers and their families, from community-based day programs that help consumers improve their social skills in community settings to programs that prepare infants and their families for school. Other services help consumers live in their own homes and travel to activities or include adult day care and in-home respite to caregivers. In

addition to referring consumers to services designed just for the developmentally disabled population, case managers refer consumers to public school system programs or to federal, state, and local government health and social programs.

FIGURE 2

Regional Centers Contract With Providers to Fulfill Consumer Needs

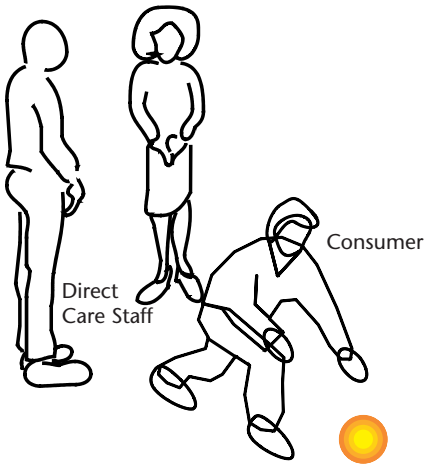
A planning team composed of the consumer, parents, guardians, or advocates, and a regional center representative jointly prepare the consumer's program plan. The planning team meets periodically to discuss the consumer's progress.



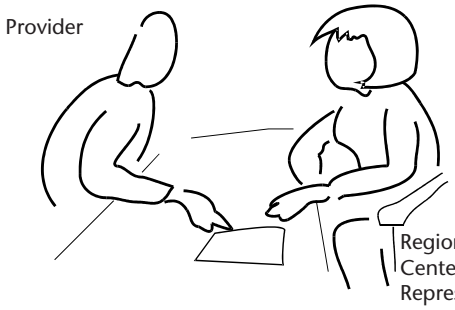
An individual program plan is an outline of agreed upon services aimed at achieving the consumer's desired goals. The plan considers the consumer's strengths, capabilities, preferences, lifestyle, and cultural background. It can include:

Objective
A consumer wants appropriate social and recreational opportunities.

Plan
The consumer will participate in a provider's recreational program.



The direct care staff work closely with the consumer to realize his or her goals and objectives.



Regional centers contract with various organizations (providers) to provide the services outlined in the consumer's plan. Additionally, they research other publicly funded programs available to consumers.

Direct Care Staff Perform Many Duties

The regional centers contract with providers, who are either private companies or nonprofit organizations, to assist the consumers with daily living or integration into the community. The providers hire direct care staff to meet their contractual obligations. For purposes of this audit, "direct care staff" are those employees whose primary duties require hands-on, face-to-face contact with consumers. This definition excludes professionals such as psychologists, nurses, and others whose primary job duties do not include direct care, as well as managers and supervisors who oversee staff.

Direct care staff perform different personal services, such as helping consumers select activities or access community resources. They also may assist consumers with daily life skills, such as managing money, cooking, and shopping, or may teach consumers self-advocacy and empowerment skills. Other direct care staff may coordinate recreational activities.

IMPOSING TRAINING REQUIREMENTS AND INCREASING WAGES WILL IMPROVE SOME DIRECT CARE SERVICES

In January 1998, the federal Health Care Financing Administration (HCFA), the agency that administers the nation's Medicaid program, reviewed certain home- and community-based services for consumers. Its review found serious deficiencies in the quality of care consumers receive, citing, among other things, that direct care staff in residential community care facilities lacked sufficient skills and training. To address this criticism, the department has established training requirements for these direct care staff and has increased their wages to retain qualified personnel.

HCFA reviewed the regional centers' records for 91 consumers; observed and interviewed the consumers at home and in their day programs; and interviewed providers, family members, and regional center staff. For purposes of this audit, we reviewed only those deficiencies HCFA identified in services from community-based providers. In this area, HCFA cited the skills and training of direct care staff. It found, for example, that direct care staff at one community care facility were unable to describe or present documentation of their training or their relevant work experience, even though they assisted consumers with

severe behavioral problems. Additionally, HCFA representatives observed that direct care staff at the visited sites could not readily identify conditions requiring prompt medical evaluation, nor did they know medical emergency procedures. The facilities also failed to offer regular, ongoing training for these direct care staff.

Responding to HCFA's findings, the State now requires the direct care staff of these facilities to complete 70 hours of training within their first two years of employment. Thus far, the State has completed the training curriculum for the first 35 hours, which includes an overview of developmental disabilities, effective communication, and basic knowledge of medications, emergency procedures, and personal care for consumers. In addition, the State has approved pay increases to these direct care staff while they meet training requirements. Their wages rose 10 percent in fiscal year 1998-99. Effective January 1, 2000, wages will rise an additional 10 percent, increasing the average hourly rate of $7 per hour to $8.48, including wages and benefits.

TWO OTHER STATE DEPARTMENTS OFFER SIMILAR PROGRAMS

The Department of Aging (Aging) and the Department of Rehabilitation (Rehabilitation) also offer services to the developmentally disabled population. Aging administers home- and community-based services to seniors, as well as to adults who become disabled after age 18, via a statewide network of 33 Area Agencies on Aging (area agencies). Under the provisions of the federal Older Americans Act of 1965, consumers can receive adult day care. Like the department's regional centers, the goal of the area agencies is to increase consumers' independence. They serve consumers directly or through nonprofit organizations or government agencies, such as cities and counties.

Likewise, Rehabilitation works with local community organizations to assist persons with disabilities to reach social and economic independence. Rehabilitation's primary goal is to rehabilitate individuals with physical and mental disabilities and place them into meaningful employment. To accomplish this, the agency sponsors supported employment services under its Habilitation Services program. Rehabilitation pays the salaries of "skill trainers" or "job coaches" who train, support, and counsel consumers at their job sites about work ethics and behavior on the job.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (JLAC) asked the Bureau of State Audits (bureau) to examine how turnover affects the ability of providers of direct care services for adults with developmental disabilities to provide quality care. Additionally, JLAC asked the bureau to identify and compare compensation and qualifications of direct care staff in community-based programs with those of staff that perform similar duties in developmental centers, regional centers, and other programs.

Of the 133,000 consumers the department serves, about 78,000 are adults (adult consumers). More than 60 percent of those adults live with a parent or guardian, independently, or in a supported-living arrangement. Because most of the consumers the department serves do not live in licensed residential facilities or developmental centers, our audit does not address the direct care staff in either of these facilities. Rather, our audit focuses on the direct care staff providers hire for selected services to adult consumers on an hourly or daily basis. Further, since the case managers at the 21 regional centers work closely with these consumers and their representatives to ensure that consumers receive necessary services, they too are included in our scope.

To understand the intent and design of the State's service delivery system, we interviewed the department's management and staff and reviewed relevant information such as department regulations, the Lanterman Act, and the Coffelt Settlement. Additionally, reviewing a January 1998 federal report and departmental budget information assisted us in understanding recent changes to the wages and training requirements for certain providers.

We surveyed 732 organizations to gather information on turnover of direct care staff, their compensation, the qualifications of staff hired, service delivery challenges, and the quality of care that consumers receive. Because some organizations provide more than one of the services we selected, we distributed 1,003 surveys. About 300 organizations returned 541 surveys, a response rate of 54 percent. We also surveyed and received responses from the 21 regional centers. The conclusions we drew from the survey are based on the organizations' actual responses. We excluded questions that organizations left blank. However, we did not perform independent tests of the accuracy of the information provided to us in the surveys. Please refer to the Appendix for additional information on our survey.

We took several steps to compare the compensation and qualifications of direct care staff working for the department's providers with those of staff who perform similar duties for developmental centers and for other state agencies. We found that staff in the developmental centers serve a different, more profoundly needy population, so their duties generally do not compare to the providers' direct care staff. We did, however, find comparable positions under certain programs administered by Aging and Rehabilitation and surveyed providers for these programs.

We mailed 180 surveys to providers offering supported employment services under Rehabilitation's Habilitation Services program. We also sent 210 surveys to 13 of Aging's area agencies and their providers. Aging does not maintain a comprehensive list of its providers, so we judgmentally selected the 13. The response rates for Rehabilitation and Aging's providers were 68 percent and 50 percent, respectively. Finally, using the California Employment Development Department's labor market information, we compared wages for positions with duties similar to those of the department's providers and the regional center's case managers.

Unfortunately, our attempt to evaluate the effect of turnover on the quality of consumers' care, using consumer complaints as an indicator, was unsuccessful. During our site visits to selected providers and regional centers, and in discussions with the department's staff, we noted that although the department has formal processes in place to address certain consumer complaints, a vast majority of complaints are handled informally by the regional centers and providers. Formal records are not maintained for all consumer complaints, so we do not know just what effect turnover has on the consumers.

Finally, to understand the status of the service delivery reform mandated by the Legislature, we interviewed the department's management and staff. We also reviewed a draft final report from the department's consultant that suggests ways to improve the regional centers' services to consumers. ■

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AUDIT RESULTS

Insufficient Funding Undermines Optimal Service Delivery to the State's Developmentally Disabled Population

SUMMARY

Inadequate state funding and budget cuts sustained in the early 1990s hamper the ability of regional centers and providers to adequately serve the State's 78,000 adult consumers. The providers we surveyed unequivocally agree that their inability to compete for direct care staff in California's flourishing job market and receiving insufficient state financial support are primary obstacles to consistently delivering quality services.

Providers also report an average turnover rate for their direct care staff of 50 percent for the past approximately 3.5 years, with most employees remaining on the job barely two years. It takes providers almost three months to replace these staff, thus creating disruptions in services and impeding continuity for the consumers, who are continually experiencing the loss of familiar faces and establishing new routines and relationships with different staff.

Although turnover is a serious problem among providers' direct care employees, it is not as much of a dilemma for the regional centers, who hire case managers to oversee the providers' delivery of services. The centers report a much lower turnover rate for their case managers during the same time period and take less time to replace the ones that move on. Specifically, the centers' case managers remain on the job an average of three years. When they do leave, they are replaced within about 2.5 months.

The regional centers do, however, contend with other obstacles. A shortage of qualified personnel and the stressful nature of the case managers' duties are the centers' primary difficulties in attracting, hiring, and retaining these staff. The delays of up to 2.5 months, coupled with insufficient state funds to increase wages and hire more staff, still disrupt the case managers' services to consumers. Most importantly, because the remaining

managers are forced to take on heavier caseloads, they have less time to properly manage their cases and address the consumers' needs. The case managers' ability to sustain regular contact with consumers is essential to ensuring quality services.

We found it difficult to assess the direct impact these factors have on individual adult consumers, but it is reasonable to conclude that this delivery system needs many improvements to reduce disruptions in their services. The Department of Developmental Services (department) is taking some steps to improve the existing system; however, until the State commits sufficient funding to this program, consumers will continue to receive less-than-optimal services to facilitate their inclusion into the community.

PROVIDER RATES AND CASE MANAGER SALARIES DO NOT REFLECT CURRENT ECONOMIC CONDITIONS

Direct care services to consumers are funded almost exclusively by the State.

The services of the providers and regional centers, whose goal is to assist consumers to integrate with their communities, are funded almost exclusively by the State. The State's system was designed to provide optimal service to adult consumers, yet insufficient funding hampers providers' and regional centers' ability to appropriately supply services and retain staff. Inadequate state funding often forces regional centers to pay providers rates that do not reflect current economic conditions, which increases the chance that consumers will receive fewer or inferior services and increases the difficulty providers have in retaining staff. Likewise, case manager salaries lag behind salaries for similar positions. The length of time it takes for regional centers to fill these vacancies and the managers' heavy caseload hinder the timely delivery of services to consumers.

Pay Rates for Some Provider Services Are Based on Outdated Cost Data

Regional centers base the amount they pay providers on the customary rate the general public pays for the same services, rates they agree upon in contract negotiations, or rates set by the department. Although the customary and negotiated rates may more accurately represent the centers' current costs, some rates set by the department may not. In particular, rates for community-based day programs—which develop the social and daily living skills of the consumers in the community, and for those who provide in-home respite services for caregivers—do not.

The department uses a method developed in the late 1980s to establish these rates: It compares the actual costs of similar programs throughout the State to develop a range of rates. The belief was that the rates would evolve over time to allow for differences in geographical areas and flexibility in program services. Beginning in fiscal year 1990-91, the department set each provider's rate based on the provider's costs from the previous fiscal year and continues to pay them as long as their costs fall below or within the allowable range. Providers whose costs exceed the upper limit of the range do not receive full compensation.

For six years the State did not provide sufficient funding to allow certain providers to receive rate increases.

If the State had increased funding, providers would have received a rate adjustment every two years; however, there were no rate increases between fiscal years 1992-93 and 1997-98. Even though the department estimated it would need $7 million to $11 million more annually to fund increased costs for day programs and in-home respite care, it was not until September 1998 that the State granted about $33 million in additional funding. Although the increase allowed these providers to receive rate adjustments, it was only enough to fund rates based on their fiscal year 1995-96 costs and to bring rates for some providers up to the lower limit of the allowable range. Furthermore, their rates will remain at this level until the department revises its current rate-setting process or receives additional state funding.

To compensate for the shortfall in state funding, some providers are at times forced to use creative means to raise extra money or add staff. They sometimes seek donations, hold fund-raisers, or even use interns from the local high school and colleges to attract competent staff. Providers believe that an inability to offer competitive compensation and benefits to staff and the lack of state financial support are the primary hurdles to delivering quality care in these programs. Please see Table 1 for all hurdles that providers reported in the survey. Responses are in the order of the department providers' frequency of response. The percentages of the top three responses of the three departments' providers are in bold face print.

TABLE 1

What Providers Believe Hinders Quality Care

Hurdles	Department Providers	Aging Providers	Rehabilitation Providers
Lack of competitive compensation/benefits	**64.7%**	**42.9%**	**65.0%**
Lack of state financial support	**55.8**	**51.4**	**61.8**
Lack of experienced and trained staff	**44.7**	**25.7**	**53.7**
High staff turnover	32.5	19.0	31.7
Insufficient resources for staff training	28.7	20.0	30.1
Insufficient technical assistance*	13.3	8.6	8.1
Lowering of minimum requirements for staff	7.9	3.8	12.2
Other†	7.2	21.0	8.1
Inability to reach consumers in remote areas	7.2	21.9	6.5

* The department's providers responded to "Insufficient regional center technical assistance," while Rehabilitation's providers responded to "Insufficient state technical assistance." However, Aging's providers responded to "Insufficient Area Agency on Aging technical assistance."

† Because they are the focus of our report, we discuss only the department's providers' specific responses below.

The department's providers other comments varied, but include concerns such as staff burnout due to stressful duties, low referral rates from regional centers, low pay for demanding jobs, and lack of jobs for consumers with significant disabilities.

Delayed Budget Adjustments Cause Case Managers' Salaries to Lag

Insufficient funding for regional center operations does not enable the centers to hire enough case managers to oversee consumer services. As a result, these managers have heavy caseloads, which may delay services to consumers or diminish their quality, and create a stressful work environment.

When developing the budget for its 21 regional centers, the department uses salary estimates for case managers that lag behind the inflation rate. Since 1978, the department has used a legislatively mandated model called the "core staffing formula" for determining the regional centers' budget for staff wages. However, between fiscal years 1990-91 and 1998-99, the core

staffing formula salary estimates remained the same, keeping case manager salaries static while California's inflation rate rose by 21 percent. The State has recently acknowledged this problem and will allot regional centers $21 million over the next two years, starting with fiscal year 1998-99, to increase the wages of current staff.

We asked regional centers to report on the three major hurdles they face in delivering quality care. One of their primary challenges is an inability to offer competitive compensation and benefits to case managers; however, the centers listed "other" concerns with equal frequency. The other concerns include heavy caseloads, the need for bilingual staff, and a shortage of available providers. The centers believe that insufficient resources for staff training and a lack of state financial support present further barriers to delivering quality direct care services. Please see Table 2 for all hurdles that regional centers reported in the survey.

TABLE 2

What Regional Centers Believe Hinders Quality Care

Hurdles	Response
Lack of competitive compensation/benefits	**47.6%**
Other*	**47.6**
Insufficient resources for staff training	**42.9**
Lack of state financial support	33.3
Lack of experienced and trained staff	28.6
High staff turnover	14.3
Inability to reach consumers in remote areas	14.3
Lowering of minimum requirements for staff	9.5
Insufficient state technical assistance	0

* The regional centers' other comments are varied, but include concerns such as the need for bilingual staff, heavy caseloads, a shortage of providers, and continually changing requirements.

Only Part of the Budget Cuts Were Restored

Between fiscal years 1991-92 and 1994-95, the State reduced funding to regional centers by more than $106 million. Centers use these funds to manage their operations and to purchase services for consumers. As of June 30, 1999, the State has given the centers only $9 million to compensate for these budget cuts. The State plans to allocate an additional $9 million for regional center operations. These funds will be used to hire more case managers. Table 3 details the budget cuts by year.

TABLE 3

Regional Centers Suffered Significant Budget Cuts

Fiscal Years	Reductions in Funds for Regional Center Operations	Reductions in Funds Used to Purchase Services for Consumers
1991-92	$15,757,340	$15,757,340
1992-93	18,620,000	31,380,000
1993-94	1,250,000	3,750,000
1994-95	5,000,000	15,000,000
Subtotal	**40,627,340**	**65,887,340**
Restoration as of June 30, 1999	(8,938,000)	0
Remaining budget shortfall	$31,689,340	$65,887,340

Source: Department of Developmental Services.

Because the department's purchases for consumers are based on historical data through November 1998, it is unable to determine exactly how much of the $66 million has not been restored.

PROVIDERS REPORT THAT LOW PAY AND FEW QUALIFIED PERSONNEL HINDER ATTRACTING, HIRING, AND RETAINING STAFF

Providers say they face significant obstacles in attracting, hiring, and retaining staff to supply direct care to consumers. Their direct care staff perform an array of services, ranging from

assisting consumers with personal care, shopping, and cooking to developing basic self-help skills for their health, money management, or self-advocacy. Because of the wide variety of duties they perform, no single set of standards or qualifications can be established. Nevertheless, those working under the three state agencies (Aging, Rehabilitation, and the department) unequivocally agree that low pay and the lack of skilled personnel keep them from hiring enough qualified staff. Please see Table 4 for more complete information from the survey. Responses are in the order of the department providers' frequency of response. The percentages of the top three responses of the three departments' providers are in bold face print.

TABLE 4

Providers' Hurdles to Adequate Staffing

Hurdles	Department Providers	Aging Providers	Rehabilitation Providers
Noncompetitive salaries/benefits	**63.8%**	**41.9%**	**71.5%**
Salary not commensurate with area cost of living	**49.0**	**39.0**	**55.3**
Lack of qualified personnel	**32.9**	**41.0**	**43.1**
Stressful nature of work	28.3	6.7	11.4
Lack of career opportunities	23.8	19.0	20.3
Insufficient labor pool	21.8	29.5	32.5
Candidates unsuitable for the type of work	20.1	21.0	16.3
Inability to hire full-time staff	19.8	21.9	20.3
Employee transportation issues	7.9	5.7	6.5
Other*	7.8	7.6	4.1
Repetitive nature of work	6.8	4.8	3.3

* Because they are the focus of our report, we discuss only the department's providers' specific responses below.

The department's providers' other comments include varied concerns, such as the inability or expense in conducting complete reference checks for prospective employees, lack of opportunity for advancement, irregular or insufficient work hours, and salaries that are not commensurate with competing employers.

Direct care staff, earning an average of $8.89 per hour, could readily become teachers' aides, hospital orderlies, or janitors, and receive comparable pay for seemingly less stressful jobs.

Based on the California Employment Development Department's (EDD) labor information, we found that jobs with comparable duties usually pay more than what direct care staff receive. Coordinating group recreational activities for boarding schools and college fraternities or sororities, for example, pays an average hourly wage of $9.64, about 75 cents per hour or 8 percent more than providers pay their direct care staff. The average hourly wage for full-time and part-time direct care staff is $8.89 per hour. Also, only 39 percent of providers offer any benefits to their direct care staff such as time off, insurance, or retirement. Direct care staff could readily become teachers' aides, hospital orderlies, or janitors to receive comparable wages for seemingly less stressful jobs.

High turnover is a further indication that these positions are difficult to fill. Providers report a 50 percent turnover rate for direct care jobs in the last approximately 3.5 years. They also say it takes almost three months to fill vacant positions, disrupting services to consumers.

Insufficient Funding Hinders Providers' Competitive Edge for Qualified Staff

Inadequate state funding leaves community-based providers in a less advantageous position to compete for employees in California's flourishing job market. Between 1993 and 1998, service industry jobs in California increased 22 percent, with strong growth specifically in home health care services and health-related personal care. Meanwhile, the average annual unemployment rate has dropped from 9.4 percent in 1993 to 5.7 percent in 1999. Strong job growth, coupled with low unemployment rates, creates more attractive employment options and diminishes providers' ability to compete for employees.

Full-Time Staff Have Higher Wages and More Benefits Than Part-Time Workers

The department's providers employ roughly equal numbers of full-time and part-time staff. In comparing staff compensation packages and turnover rates for both groups, we found that 55 percent of the providers offer some benefits to full-time staff, yet only 25 percent offer any to part-time staff. Table 5 indicates the differences in pay and benefits.

TABLE 5

Full-Time Staff Receive Higher Wages and More Benefits and Stay Longer

Category	All Direct Care Staff	Full-Time	Part-Time
Average hourly wage	$8.89	$9.37	$8.26
Percent of providers offering any benefits	39%	55%	25%
Turnover rate	50%	43%	57%

Source: Bureau of State Audits' survey results.

Note: The turnover rate was computed using an average of rates from January 1, 1996, to May 31, 1999.

COMPENSATION FOR DIRECT CARE STAFF IS NOT UNIFORM THROUGHOUT THE STATE

Providers working with the three state departments report differences in wages, turnover rates, and the time it takes to fill vacant positions. For example, the department's providers pay their direct care staff varying wages, depending on where they work. Also, these providers usually pay employees with only a high school education more than Aging's and Rehabilitation's providers do. However, for some positions with comparable duties, providers working with Aging pay higher wages and require staff to have more education.

Overall, direct care staff under all three departments earn average wages ranging between $8.60 and $9.10 per hour. However, we noted differences among—as well as within—the departments in average hourly wages, turnover rates, and the time it takes to fill vacant positions for full-time versus part-time staff. Please see Table 6 for a detailed comparison for providers of all three departments.

TABLE 6

Wages, Turnover, and Vacancy Rates for Direct Care Staff Under Three State Departments

	Average Hourly Wage	Turnover Rate	Average Number of Months to Fill Vacancies
All Positions			
Department	**$8.89**	**50.0%**	**2.9**
Aging	8.59	31.5	1.7
Rehabilitation	9.11	51.0	4.5
Full-Time Only			
Department	**9.37**	**42.5**	**2.7**
Aging	10.68	30.6	1.9
Rehabilitation	9.29	41.9	4.1
Part-Time Only			
Department	**8.26**	**56.6**	**3.0**
Aging	7.57	31.9	1.4
Rehabilitation	8.35	61.8	4.9

Source: Bureau of State Audits' survey results.

Note: The turnover rate was computed using an average of rates from January 1, 1996, to May 31, 1999.

Bay Area Providers Pay Substantially More Than Most Providers Pay Elsewhere

Depending on their location, some direct care staff working for the department's providers can receive significantly higher wages—sometimes over $3 per hour more—than do staff in other areas. For instance, staff working in the far northern region of the State make an average of $7.58 per hour, yet staff working within the counties of Marin and San Mateo make an average of $10.78 per hour. Figure 3 shows average hourly wages by geographical area.

FIGURE 3

Average Hourly Wages for Direct Care Staff Can Vary Sharply by Geographical Area

Source: Bureau of State Audits' survey results.

*Los Angeles includes seven regional centers.

The Department's Providers Pay Higher Wages to Some Staff Than Other State Agencies Do

The department's providers generally pay more than other state agencies do for certain direct care staff and even report lower turnover rates for some positions. Respite workers who work mostly part-time, for example, earn an average of $7.51 per hour from the department's providers while those who work for Aging's providers earn $7.18, the lowest rates for all positions we compared. Although providers for both departments require respite workers to have comparable experience, more of the department's providers offer training and benefits. However, both experience similar difficulty in filling vacancies for respite worker positions, even though the department's providers report a lower turnover rate.

Regular respite workers provide the consumer with companionship and their families or caregivers with temporary relief. Some of their duties include light housekeeping, cooking, and assisting with personal care, shopping, or personal business.

The department's providers generally require:

- high school education or its equivalent
- about 11 months of experience

And report that:

- about 64 percent offer training
- about 39 percent offer benefits

Aging's providers generally require:

- high school education or its equivalent
- about 11 months of experience

And report that:

- about 32 percent offer training
- about 21 percent offer benefits

Similarly, the department's providers pay their socialization coaches on average $9.24 per hour while providers for Aging pay just $7.45 per hour. The differences in wages may be reflective of the additional responsibility for planning activities that the department's providers require. However, the turnover rates are quite different; the department's providers report a rate of 50 percent while providers for Aging report a comparatively low rate of 30 percent. Conditions do not improve when the department's providers attempt to fill these vacant positions. They take nearly three times longer to fill socialization coach positions than providers for Aging do.

Socialization coaches primarily plan, prepare, and conduct activities to develop consumers' social skills.

Department's providers generally require:

- high school education or its equivalent
- about 12 months of experience

And report that:

- about 29 percent offer training
- about 27 percent offer benefits

Aging's providers generally require:

- high school education or its equivalent
- about 10 months of experience

And report that:

- about 47 percent offer training
- about 41 percent offer benefits

Further, the department's providers pay job coaches $1 more per hour, or 14 percent more, than Rehabilitation's providers pay, despite the fact that the experience requirements are comparable. Turnover rates vary greatly and, interestingly enough, seem to depend on whether the position is full-time or part-time. For example, the turnover rate is more than 70 percent for full-time job coaches working with the department's providers but only 42 percent for full-time coaches with Rehabilitation's providers. On the other hand, the turnover rate of 30 percent for part-time coaches working for the department's providers is significantly lower than the 62 percent turnover rate for part-time coaches working with Rehabilitation's providers. The department's providers also take much less time to fill vacant job-coach positions.

Job coaches train, support, and counsel consumers on the job site regarding work ethics and behavior. They also assist in developing job sites, coordinating public relations, and community interactions.

Department's providers generally require:

- high school education or its equivalent
- about 14 months of experience

And report that:

- about 44 percent offer training
- about 39 percent offer benefits

Rehabilitation's providers generally require:

- high school education or its equivalent
- about 11 months of experience

And report that:

- about 98 percent offer training
- about 78 percent offer benefits

The Department of Aging's Providers Offer Better Wages for Remaining Positions in Our Survey

The department's providers pay significantly less for life skills coaches and recreation program leaders than providers contracting with Aging. Specifically, the department's providers pay life skills coaches an average of $9.69 per hour while providers for Aging pay an average of $13.67. The pay difference could be attributed to the additional educational requirements that Aging providers generally require. Turnover rates under the department are higher as well. The department's providers have a turnover rate of more than 48 percent, while the rate for providers under Aging is about 33 percent. Additionally, it takes the department's providers more than three months to fill vacant positions compared with providers for Aging, who take about one month.

Life skills coaches plan and conduct activities for consumers that develop their daily living skills.

Department's providers generally require:

- high school education or its equivalent
- about 16 months of experience

And report that :

- about 44 percent offer training
- about 42 percent offer benefits

Aging's providers generally require:

- often more than high school education or its equivalent
- about 18 months of experience

And report that:

- about 48 percent offer training
- about 48 percent offer benefits

Recreation program leaders organize and lead diversified recreation, social, and developmental activities.

Department's providers generally require:

- high school education or its equivalent
- about 12 months of experience

And report that:

- about 55 percent offer training
- about 50 percent offer benefits

Aging's providers generally require:

- often more than high school education or its equivalent
- about 14 months of experience

And report that:

- about 48 percent offer training
- about 45 percent offer benefits

Recreation program leaders are additional direct care staff who get significantly lower wages from the department's providers. In fact, they make about $2.50 less per hour than employees who work for Aging's providers in the same classification. Again, as with its life skills coaches, Aging's providers generally require more education for these recreation positions and have a lower turnover rate (30 percent) than the 45 percent rate the department's providers experience. Additionally, the department's providers take almost twice as long to fill their vacancies.

DELAYS IN FILLING CASE MANAGER POSITIONS DISRUPT SERVICE

Although the situation is not as bleak as it is for providers seeking direct care staff, regional centers have similar difficulties in attracting, hiring, and retaining staff for their critical case management positions. Most case managers work full-time and stay on the job at least three years. Although their turnover rate for the past approximately 3.5 years was a fairly low 14 percent, when case managers do leave, it takes about 2.5 months to fill the vacancies. Centers contracting with the department also take more than twice as long to fill these vacancies as those who contract with Aging, which can create lengthy disruptions in consumer services.

Case managers assist consumers by participating in their plan development, purchasing services, making referrals to available public programs, and monitoring their progress.

For this position, regional centers report that:

- There is a 13.7 percent turnover rate
- It takes about 2.6 months to fill vacant positions

They generally require:

- A four-year degree
- About 2.4 years of experience

Most regional centers state that they offer new employee training and benefits 100 percent of the time to their full-time case managers.

The regional centers explained that several factors contribute to delays in replacing their case managers. Listed in order of importance, their obstacles to attracting, hiring, and retaining case managers are lack of qualified personnel, stressful nature of the work, noncompetitive salaries and benefits, lack of career opportunities, and an insufficient labor pool. Please see Table 7 for more information on responses to the survey.

TABLE 7

Regional Centers' Hurdles to Adequate Staffing

Hurdles	Response
Lack of qualified personnel	**57.1%**
Stressful nature of work	**47.6**
Noncompetitive salaries/benefits	**33.3**
Lack of career opportunities	**33.3**
Insufficient labor pool	**33.3**
Other*	23.8
Salary not commensurate with area cost of living	19.0
Repetitive nature of work	9.5
Candidates unsuitable for the type of work	4.8
Inability to hire full-time staff	0
Employee transportation issues	0

* Regional centers' other comments are varied, but include concerns about the excessive documentation required and the lack of opportunities to obtain work hours needed for licensure.

Delays in filling these vacant positions may mean that consumers lose contact with the person who is key to ensuring that they get services or to making important decisions concerning their plans. Furthermore, the remaining case managers must absorb the consumers into their own caseloads. Increased caseloads create a stressful work environment for the managers and hamper them from properly addressing consumers' needs.

Recent reviews by a federal agency and a consultant underscore the stressful work environment that case managers must endure. In January 1998, the federal Health Care Financing Administration (HCFA) noted that high turnover and heavy caseloads basically limit case managers' duties to crisis management. When case managers must focus only on urgent issues, their productivity decreases. They do not have the time to become familiar with individuals' needs and developmental progress. The consultant reviewing the department's budget process for

regional center operations further reported that the most frequent consumer and provider complaint was the inability to talk to the appropriate regional center staff on a timely basis. This suggests that case managers are too busy to properly follow up with their consumers.

Although Regional Center Case Managers Earn Wages Comparable to Those Working in Aging Programs, the Pay Still Trails the Market Rate

Individuals in social work positions with similar functions earn an average of $18.55 per hour, or 6 percent more than regional center case managers.

Most regional centers require new case managers to hold at least a bachelor's degree and have approximately 2.5 years of experience, while almost a quarter require their case managers to have certifications or licenses. Although the average wage for case managers working for the regional centers is about $17.50 per hour, the range of salaries varies a great deal. The average minimum salary is as low as $14.50 per hour and the average maximum rate is more than $21 per hour, yet there is no pattern by geographic area. The regional centers in Los Angeles illustrate this point. Two of the seven centers pay their case managers wages below the average minimum, but managers in other Los Angeles centers earn closer to the average maximum wage.

Furthermore, the regional center case managers earn wages comparable to their contemporaries who contract with Aging to provide similar services to seniors. Regional center case managers make about 40 cents an hour more than those working for Aging's providers, who earn an average $17.10 per hour, but their requirements for education, licenses, or certifications are less stringent.

Finally, case managers working for both the regional centers and Aging's providers earn about 6 percent less than the average the EDD reports for equivalent positions in private and public industry. According to EDD's annual survey of employers, individuals in social work positions with similar functions earn an average of $18.55 per hour and most have attended more than two years of college.

THE STATE MUST UNDERTAKE INTERIM MEASURES TO ALIGN ITS FUNDING WITH PROGRAM COSTS

The department is taking some steps to improve the existing service delivery system, such as examining ways to revise the method it uses to pay certain providers and engaging a consultant

to evaluate its budget process for regional centers. However, unless the State supports the department's efforts by allotting sufficient funds for this program, the efforts to improve this service delivery system will not succeed.

One struggle the department faces in implementing its new rate structure is how to measure the quality of service that consumers receive from providers. Each consumer's plan is different, so the department's challenge is to devise an equitable evaluation of the providers' performance that takes into account consumers' progress toward their goals. However, the primary struggle will be obtaining sufficient funding to implement any changes the department makes to the existing service delivery system.

As part of the Budget Act of 1998, the Legislature directed the department to reform its rate structure. The department is developing a new performance-based rate structure for certain providers, which will be based on consumer outcomes. In the fall of 1998, the department convened a service delivery reform committee composed of interested stakeholders, including consumers, their families, providers, and service provider associations, to assist in the development of its rate structure. The committee's mission is to assure that services are consistent with the intent of the Lanterman Developmental Disabilities Services Act (Lanterman Act).

The department believes that system reforms will provide consumers with enhanced services focusing on individual outcomes and satisfaction.

There are also subcommittees for the five programs under review: residential services, supported living, adult day care, infant development, and respite care. For these programs, the committee plans to update the definition of services available to consumers, adopt personal outcome statements, establish performance indicators and measurements, reach an agreement on the system for paying providers, and recommend changes to the existing laws and regulations. The department expects to take up to four years to fully implement the committee's recommendations.

The department expects that its significant reforms will reflect a continuing shift in its service delivery system. Currently, the regional centers purchase services for consumers and their families based on the availability of programs that providers offer. The department believes that under the new system, instead of placing consumers in available programs, regional centers will develop services that focus on consumer outcomes and satisfaction. Further, providers will be held accountable for achieving consumer goals and evaluated on their success in

ensuring that goals are met. The new system also will contain incentives for providers to improve and enhance services to consumers. However, unless the State apportions sufficient funding for these changes, consumers will continue to receive less-than-optimal services despite the department's efforts.

Key Improvements to the Regional Center Budget Process Will Require $14 Million

Recognizing that the "core staffing" formula it uses to determine regional center funding is outdated, the department hired a consultant to develop a more appropriate budget methodology. In a June 1999 draft of its final report, the department's consultant commented that the "core staffing formula has outlived its usefulness and was designed to budget for a different environment than exists today." As one example, the formula does not include sufficient resources for the centers' information technology and training support staff. The department estimates it needs $14 million to fund these and other essential positions that the existing formula excludes.

RECOMMENDATIONS

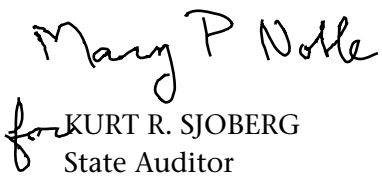
To ensure that consumers receive optimal services from the State in accordance with the Lanterman Act, the Legislature must take interim measures to align state funding with program costs until the department completes its reforms. Any additional funding should be earmarked specifically for increasing compensation for qualified direct care staff and reducing the caseloads for regional center case managers.

To ensure that providers continuously receive funding that reflects current economic conditions, thus allowing them to compete for qualified direct care staff, the department should expedite its service delivery reforms.

Finally, to effectively oversee consumer plans at the regional centers, the department should carefully consider its consultants' recommendations for the regional center budget process and implement those it deems beneficial as quickly as possible.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG
State Auditor

Date: October 20, 1999

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APPENDIX

A Description of Our Survey Process and Selected Results

This appendix provides a more thorough description of our survey and a summary of results for certain questions organizations providing services to adult consumers in the community (providers) and the 21 independent, nonprofit regional centers (regional centers) answered.

Using the Department of Developmental Services' (department) databases, we created a listing of purchases for consumers by service code for the period of July 1, 1998, to March 31, 1999. These data allowed us to select the services described in our glossary, which are provided on an hourly or daily basis to consumers in the community. From this list, we excluded providers who were identified as parents and those who did not provide services more than once during the period. We also obtained a list from the department for providers of supported living services.

In developing our survey questionnaires, we conducted site visits to obtain an understanding of the practical implementation of the service delivery system and to gain some insight into the challenges that both providers and regional centers face. We asked representatives from the department, Association of Regional Center Agencies, California Rehabilitation Association, ARC, and California Coalition of United Cerebral Palsy Associations to assess our cover letter and survey. In addition, we asked them to describe any other concerns or questions we should address. We assessed their responses and made any necessary changes to the survey questionnaires before distributing them to the regional centers and providers.

We employed the assistance of a consultant to design our survey, tabulate the survey responses, and provide us with various reports to allow us to analyze and interpret the results. However, we did not perform independent tests of the accuracy of the information provided to us in the surveys.

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GLOSSARY

The following is a description of the services that we examined in our report:

Activity Center: These centers serve adults that have most basic self-care skills and some ability to interact with others or make their needs known, and an ability to respond to instructions. Activity centers develop and maintain the functional skills required for self-advocacy, community integration, and employment.

Adult Day Care Facility: Centers that provide nonmedical care to persons 18 years of age or older who need personal services, supervision, or assistance essential for daily living or for their protection on less than a 24-hour basis.

Adult Development Center: Centers that help adults acquire self-help skills. Individuals who attend these centers generally need sustained support and direction to interact with others, make their needs known, and respond to instructions. Adult development center programs develop and maintain the functional skills required for self-advocacy, community integration, employment, and self-care.

Behavior Management Program: These services are for adults with severe behavior disorders or dual diagnosis who, because of their behavior problems, are not eligible for any other community-based day program. A consumer with a dual diagnosis is developmentally disabled and mentally ill.

Community Integration Training Program: A program that teaches consumers to interact with others in the community.

Homemaker Program: A program that provides services to maintain, strengthen, or safeguard the care of individuals in their homes.

Independent Living Program: Independent living trains adult consumers for a self-sustaining, independent living situation in the community. Independent living programs focus on functional skills training for consumers with basic self-help skills and those who, because of their physical disabilities, do not possess basic self-help skills. These programs employ aides to assist adult consumers in meeting their personal needs.

In-Home Respite Services: Services furnished in the consumer's own home designed to temporarily relieve family members from the constant demands of caring for a consumer; assist family members in maintaining the consumer at home; provide appropriate care and supervision to protect the consumer's safety in the absence of family members; and assist the consumer with basic self-help needs and other activities of daily living, including interaction, socialization, and the continuation of daily routines.

Mobile Day Program: Services provided to consumers who are unable to attend day programs outside their homes.

Social Recreation Program: A program that provides community integration and self-advocacy training in recreational and leisure pursuits.

Socialization Training Program: A program that provides socialization opportunities for school age developmentally disabled persons.

Supported Living Services: Services provided to consumers who choose to live in their own homes. These services are offered regardless of the degree of disability and are provided as often as needed. The choice to live in a supported living arrangement must be specified in the consumer's individual program plan. Typically, a service agency works with the consumer to coordinate needed services.

BENEFITS EMPLOYERS OFFER THEIR DIRECT CARE STAFF

Provider responses to the question: What benefits do you offer your employees?

TABLE 8

Benefits Offered to Direct Care Staff

	Department Providers	Aging Providers	Rehabilitation Providers
Insurance			
Medical	29.6%	33.2%	58.7%
Dental	25.7	28.0	54.1
Vision	13.8	20.3	34.0
Life insurance	18.1	21.0	42.3
Other insurance*	9.2	9.5	20.6
Retirement			
Other retirement*	13.8	16.9	34.5
Pension	7.3	14.7	20.1
Time off benefits			
Holiday	30.6	40.2	67.0
Vacation	30.3	39.7	63.9
Sick leave	27.8	38.4	61.8
Other time-off benefits*	11.0	15.5	29.4
Other benefits*	9.8	12.2	22.2
No answer	60.2	58.5	22.2

* Because they are the focus of our report, we discuss only the department's providers' specific responses below.

Some of the department's providers report they offer other insurance for long- and short-term disability, other retirement includes tax-sheltered annuities or retirement options, and other time-off benefits for personal and bereavement leave. Additional other benefits that some of the department's providers offer include cafeteria plans, employee assistance programs, educational assistance, health club or gym memberships, and reimbursement for mileage or personal automobile use.

BENEFITS REGIONAL CENTERS OFFER THEIR CASE MANAGERS

Regional center responses to the question: What benefits do you offer your employees?

TABLE 9

Benefits Offered to Case Managers

Benefits	Response
Insurance	
Medical	84.6%
Dental	84.6
Vision	51.3
Life insurance	87.2
Other insurance*	66.7
Retirement	
Other retirement*	38.5
Pension	84.6
Time off benefits	
Holiday	84.6
Vacation	84.6
Sick leave	84.6
Other time-off benefits*	56.4
Other benefits*	59.0
No answer	7.7

* Some of the regional centers report they offer insurance for long-term disability, other retirement that includes tax-sheltered annuities, and other time-off benefits for educational and bereavement leave.

NEW EMPLOYEE TRAINING EMPLOYERS OFFER THEIR DIRECT CARE STAFF

Provider responses to the question: What training do you provide new employees?

TABLE 10

New Employee Training for Direct Care Staff

	Department Providers	Aging Providers	Rehabilitation Providers
Policies and procedures	46.3%	44.3%	97.9%
Reporting requirements such as special incidence reporting	45.3	42.2	95.3
Consumer rights and services	45.1	36.6	96.9
Health issues such as personal care, nutrition, and infection control	44.7	38.2	85.1
Safety issues including first aid and CPR	44.4	41.5	91.2
Other*	12.6	12.2	21.2
No answer	53.3	53.3	2.1

* Because they are the focus of our report, we discuss only the department's providers' specific responses below.

Some of the department's providers report they offer other types of training to new employees, including behavior management, crisis intervention and prevention, health and safety issues other than those listed above, and training on the delivery system.

NEW EMPLOYEE TRAINING REGIONAL CENTERS OFFER THEIR CASE MANAGERS

Regional center responses to the question: What training do you provide new employees?

TABLE 11

New Employee Training for Case Managers

Training	Response
Policies and procedures	94.9%
Reporting requirements such as special incidence reporting	94.9
Consumer rights and services	94.9
Quality assurance	87.2
Technical/computer training	89.7
Other*	41.1
No answer	5.1

* The regional centers report they offer other training to new employees. Each regional centers' training is distinct.

CONTINUING EDUCATION EMPLOYERS OFFER THEIR DIRECT CARE STAFF

Provider responses to the question: What continuing education do you offer your employees?

TABLE 12

Continuing Education for Direct Care Staff

	Department Providers	Aging Providers	Rehabilitation Providers
Behavior training such as intervention and coaching strategies	38.8%	28.9%	84.0%
Safety issues such as disaster preparation, and drug and alcohol awareness	37.6	38.8	69.1
Federal, state, and local requirement updates	29.3	28.7	51.5
Interpersonal skill development, including conflict resolution and leadership	27.4	31.6	50.0
Other*	8.1	9.9	6.7
No answer	56.4	56.4	11.9

* Because they are the focus of our report, we discuss only the department's providers' specific responses below.

Some of the department's providers report they offer other continuing education in health and safety issues other than those listed above, including CPR, first aid, defensive driving and vehicle safety, and training on the delivery system.

CONTINUING EDUCATION REGIONAL CENTERS OFFER THEIR CASE MANAGERS

Regional center responses to the question: What continuing education do you offer your employees?

TABLE 13

Continuing Education for Case Managers

Continuing Education	Response
Behavior training such as intervention and coaching strategies	59.0%
Safety issues such as disaster preparation, and drug and alcohol awareness	66.6
Federal, state, and local requirement updates	71.8
Interpersonal skill development, including conflict resolution and leadership	76.9
Other*	20.5
No answer	17.9

* The regional centers report they offer other continuing education, but the subject matter varies.

SUGGESTIONS FROM PROVIDERS AND REGIONAL CENTERS ON IMPROVING THE QUALITY OF SERVICES THAT CONSUMERS RECEIVE

We asked the department's providers how their programs could be improved. We also asked regional centers how services for consumers could best be improved. The following represents a few of their verbatim responses.

Providers' Comments:

- By being able to offer competitive salaries and therefore increasing ability to hire and retain qualified staff.
- Continue to assist with rate increase and training.
- Increase our rates enough to allow us to compete in the marketplace.
- Increase salaries to reduce staff turnover, which leads to consistency in services provided to clients.
- Improve vendor payment rates so as to make it a cost-effective, as well as personally rewarding, business choice.
- Increasing wages to attract and maintain people who would choose human services as a career rather than attracting those who are looking for a "job."
- There needs to be more funding to pay higher wages and increase benefits. That will alleviate some staff turnover, allow us to hire more qualified staff, and be able to provide higher quality care to our clients.

Regional Centers' Comments:

- Reduce caseloads lower than 1:62.
- Continue to lower caseload size and improve salaries.
- Funding level consistent with federal and state mandates, and consistent with area cost of living.
- We have been forced to lower our years-of-experience requirement from four to three to two due to low salaries—make budget appropriate to the task.
- The capability of individual case managers to know their clients by increasing face-to-face contact, and the knowledge of resources and expertise of case managers.

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Agency's response provided as text only.

Department of Developmental Services
1600 Ninth Street, Room 310, MS 3-3
Sacramento, CA 95814

October 8, 1999

Mr. Kurt R. Sjoberg
State Auditor
California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Mr. Sjoberg:

> Draft Audit Report Entitled "Department of Developmental Services: Without Sufficient State Funding, It Cannot Furnish Optimal Services To Developmentally Disabled Adults"

Department of Developmental Services (DDS) appreciates the opportunity to provide feedback on this important issue. First, we wish to compliment the work done by your audit team, who were very courteous, open, and willing to listen to the many people who had perspectives on this issue which is reflective in the quality of the product that was produced.

RESPONSE TO RECOMMENDATIONS

DDS appreciates the attention being paid to issues which directly affect the quality of services provided to our clients. We share the concern expressed by the audit team, and by our many constituents, regarding the importance of ensuring the availability of qualified and competent direct care staff for all of the programs serving persons with developmental disabilities.

Towards this end, the State has, over the past two years, taken a number of actions designed to enhance service quality. In doing so, we have taken a broad approach that views the system as a whole, rather than focusing on single issues in isolation. We believe this is essential because our consumers, by and large, interact with an entire system, not simply with one service or provider.

Thus, over the past two years we have worked to focus our improvements on key elements that will improve the systemwide functioning of our programs. Some of the salient changes include the following:

- Wage Increases and Training Programs for direct care staff in community care facilities. Through these efforts, staff wages will increase by an average of 20 percent, and the staff will receive training and must pass a competency exam to continue working with consumers living in the community. This cost of these will exceed $90 million annually.

- Day Program and In-Home Respite Rate Increases. A total of $27.4 million was appropriated for this purpose in 1998-99. Also added was a requirement that the Department redesign its day program service system so as to establish a new performance-based consumer outcome rate setting methodology.

- Increase in Regional Center Case Managers. A total of $56 million has been funded (1)* to add 855 additional case managers in the regional centers, and to improve the salaries of these staff.

- Quarterly Monitoring of Consumers in the Community. More than $9 million was added to provide sufficient staffing to enable the regional centers to conduct quarterly face-to-face visits with consumers in all types of community living situations.

- Clinical Teams. Thirty-five teams of health professionals were established at the regional centers, at a cost of $10 million annually. These teams provided the resources to ensure that consumers have access to medical, dental and behavioral services they need, as well as providing the regional centers with the ability to carefully monitor consumer health care .

(2) • Minimum Wage. Over $40 million was provided to increase the wages of the direct care staff working both in day programs and in residential programs.

The foregoing augmentations reflect the State's legitimate interest in improving the care of–and the lives of–persons with developmental disabilities. Moreover, it is important to remember that, while these improvements constitute the largest and most critical changes to our service system, a substantial number of other enhancements have been made as well in areas such as rates for supported living and increased access to community health care.

This is not to say that we believe the current service system is perfect and needs no further change. On the contrary, we continually review the functioning of our system, utilizing not only information from automated data systems, but input from clients and

* California State Auditor's comments on this response appear on page 49.

their families, regional center staff and management, the Legislature, advocacy groups and interested external parties. All of these voices have helped guide the direction we have taken over the past few years, and can share in the credit for the improvements we have put in place. We will continue listen to and work with these individuals in the future.

At the present time, one of our major activities involves reforming the system by which we provide residential services, day programs, supported living programs, respite services, and infant programs to thousands of individuals. As in prior efforts, we are involving a broad array of interested parties. This effort is as complex as it is critical, yet it offers the promise of establishing not only a more equitable rate system, but a more consumer-oriented service model that is focused on meaningful individual outcomes.

With respect to the report's recommendation regarding regional centers' case management staff, DDS has just received the final report by the consultant. Please note that the study conducted by the consultant is much broader than case management staff and addresses all staffing needed by regional centers to meet state and federal mandates. DDS is reviewing the report and will forward its recommendations to the Legislature.

Lastly, though the report recommends that any available funds be earmarked for increasing compensation for direct care staff and reducing the caseloads of regional center managers, we believe it is important that expenditure decisions be made in the context of the needs of our service system as a whole. It is important that all constituencies with an interest in our issues have an opportunity to discuss expenditure priorities, and we believe that our annual Budget and Legislative processes afford the best opportunities for such participation.

Again, DDS wishes to thank you and your staff for the work done on this report.

Cordially,

(Signed by: Kenneth Buono for)

CLIFF ALLENBY
Director

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COMMENTS

California State Auditor's Comments on the Response From the Department of Developmental Services

To provide clarity and perspective, we are commenting on the Department of Developmental Services' (department) response to our audit report. The numbers correspond to the numbers we have placed in the response.

(1) The department's depiction of the use of the $56 million is not quite accurate. Only $39 million has been specifically earmarked to reduce regional center case manager's workloads from staff to consumer ratios as high as 1:90 to 1:62 and to improve the salaries of these staff. The department is silent on the fact that the remaining amount will fund other than case manager positions. Some regional centers, as stated on page 43 of the report, believe that services to consumers can be improved by further reducing caseloads.

(2) Compliance with revisions to the State's minimum hourly wage does not demonstrate a departmental initiative to increase the wages for direct care staff.

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps

FUNDING THE WORK OF CALIFORNIA'S REGIONAL CENTERS

Prepared by the
Association of Regional Center Agencies

September 2013

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FUNDING THE WORK OF
CALIFORNIA'S REGIONAL CENTERS
EXECUTIVE SUMMARY

The Lanterman Act (Division 4.5 of the Welfare and Institutions Code) mandates the Department of Developmental Services (DDS) to "contract with an appropriate private nonprofit corporation or corporations to operate regional centers…"[i] The regional center system has grown and evolved from two regional centers in 1966 serving fewer than a thousand clients to 21 regional centers serving more than 259,000 consumers and their families. Regional center staff perform outreach and community education, intake and assessment, eligibility determination, resource development, and on-going case management services. They also vendor and pay the thousands of organizations and individuals who provide services to regional center consumers.

The regional center budgets are divided into two parts, Purchase of Service (POS), which provides funding to pay the many service providers in the community, and Operations (OPS), which provides funding to pay the regional center staff and all the expenses associated with operating a multi-million dollar business.

Over the past years the types of services purchased for consumers have expanded greatly. The recordkeeping requirements have also expanded as more reliance has been placed on capturing federal funds to operate the regional centers. As this expansion occurred, there have also been several fiscal crises in California which has resulted in cut-backs to the regional center budgets. Both the Purchase of Service and Operations budgets have been affected. This paper focuses on problems caused by the concurrent expansion of workload requirements and Operations budget reductions.

These problems can be categorized into four groups: (1) actions leading to a direct reduction in the OPS budget without a corresponding decrease in operations workload, (2) actions imposing additional workload for which no additional, or inadequate, funding

was added to the OPS budget, (3) inaction with respect to updating the OPS budgeting formula, and (4) design flaws inherent in the OPS budgeting formula.

1. Actions Leading to a Direct Reduction in the OPS Budget Without a Corresponding Decrease in Operations Workload

This is exemplified by unallocated reductions to the OPS budget. The Administration will arbitrarily reduce the budget to meet the state's overall budget requirements and leave the regional centers to determine how they will absorb those reductions and still meet the many mandated requirements for which regional centers are responsible.

2. Actions Imposing Additional Workload for Which no Additional, or Inadequate, Funding was Added to the OPS Budget

Over the past thirty years there have been numerous legislative and regulatory changes which have increased the workload to regional center staff, both in case management and in administration, without any increase (or an inadequate increase) in the OPS budget. These have ranged from increased data gathering from consumers and their families to increased monitoring of facilities and programs, to increased reporting to DDS.

3. Inaction with Respect to Updating the OPS Formula to Keep Pace with the Increasing Costs of Doing Business.

The core staffing formula is the basis for the OPS budget allocations to the regional centers. It was originally designed with the salaries in the core staffing formula comparable to State salaries for similar positions. As State salaries increased, the salaries in the core staffing formula had increased. Then in FY 1991-92, as part of the state's response to a budget crisis, the salaries in the core staffing formula ceased to be adjusted as state salaries increased. Therefore, the salaries in the core staffing formula today, with some minor adjustments, remain at the 1991 levels.

The Lanterman Act specifies that regional centers must adhere to certain caseload ratios (ratios of Consumer Program Coordinators [CPCs] to consumers served).

However, since salaries have been frozen at 1991 levels, regional centers are unable to hire sufficient CPCs to meet the required caseload ratios and, consequently, puts over $1 billion in federal funds at risk.

4. Design Flaws in the OPS Formula

There are many design flaws in the core staffing formula that further complicates the problem. When the core staffing formula was designed, regional centers served on the average about 2,000 consumers each. Now the average number of consumers served by regional centers is about 7,000. As with any organization, as it grows in size there is an increased need for middle managers. The core staffing formula does not adequately allow for middle management and support staff to properly operate the larger organizations regional centers have become.

Another design flaw in the core staffing formula is the Fringe Benefit rate of 23.7%. This is wholly inadequate since the Department uses a rate of 41.6% for the Developmental Center staff. The average fringe benefit rate for regional centers is 34%.

Over the years there have been a number of studies conducted to update the core staffing formula, most notably the Citygate study of 1999. The Department used the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal was supported within the Administration, but is not included in the Governor's budget because of a severe economic downturn.

CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[ii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the

primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has “accepted a responsibility” is directly threatened.

I. INTRODUCTION

Regional centers are a critical publicly-funded safety net for 259,000 of California's most vulnerable citizens. Regional centers provide Californians who have a developmental disability with community-based services and supports to allow children to remain in their family homes and adults to reach the highest level of independence possible. However, chronic underfunding is undermining the regional centers' ability to meet their mandate under the Lanterman Act and the needs of these individuals and to comply with their statutory and contractual responsibilities. Therefore, the Association of Regional Center Agencies (ARCA) believes it is essential that those who influence and make public policy understand the seriousness of this issue, particularly as the state's improving economic situation begins to allow for fiscal restoration of vital public programs.

This paper is designed to: (1) provide information on the existing budgeting methodology used by the state to fund regional center operations, (2) identify the reasons and extent to which the regional center operations budget is underfunded, and (3) alert the public and policy makers that this situation cannot continue without directly threatening the health and well-being of consumers, and the continued receipt of over $1 billion in federal funds to the state.

This paper's focus on the operations side of the budget should not be construed as diminishing the serious underfunding that also exists in the purchase of services budget. ARCA addresses the purchase of service funding issue in its position statement titled "The Budget Crisis Affecting California's Regional Centers."

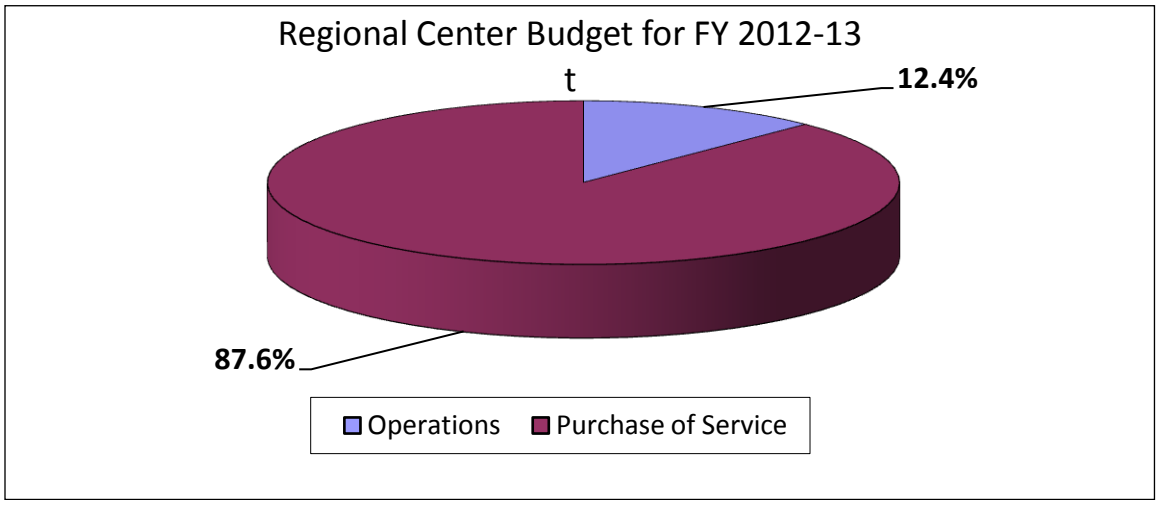
II. BACKGROUND

A. Budget Overview - The state will provide regional centers approximately $4.2 billion in the FY 2013-14. This funding is budgeted and allocated in two distinct categories: purchase of services (POS) and operations (OPS).

Funds allocated for POS are used to purchase services and supports from community-based service providers. These services and supports are needed by consumers and their families to implement consumers' individual program plans (IPPs), or for consumers under the age of three, their individualized family service plans (IFSPs). These IPPs and IFSPs are plans developed by a planning team that include the consumer, the consumer's parents (for a minor), regional center representatives, service providers, and others as appropriate or as invited by the consumer. These plans describe the services required by the consumer to improve or ameliorate their condition, identify who will provide those services, and who will pay for the services.

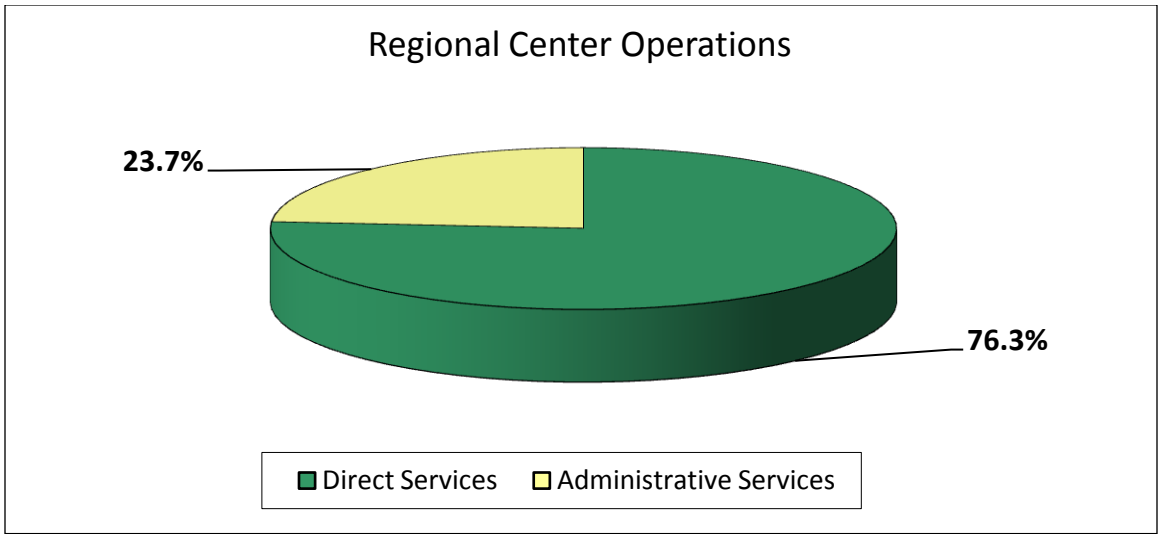
The OPS budget funds a regional center's costs related to personnel and benefits, insurance, leases, equipment, information technology, accounting/payment functions, personnel management, consultant services, independent financial audits, consulting/legal services, board support, travel, office facilities, and other administrative/managerial expenses. Chart 1 shows the relative percentages of the total budget allocated for OPS and POS.

Chart 1



The following chart (Chart 2) shows how the descriptor “OPS budget” is misleading, in that it connotes administrative costs, whereas more than three-fourths of the regional center OPS budget actually funds direct services to consumers and their families.

Chart 2

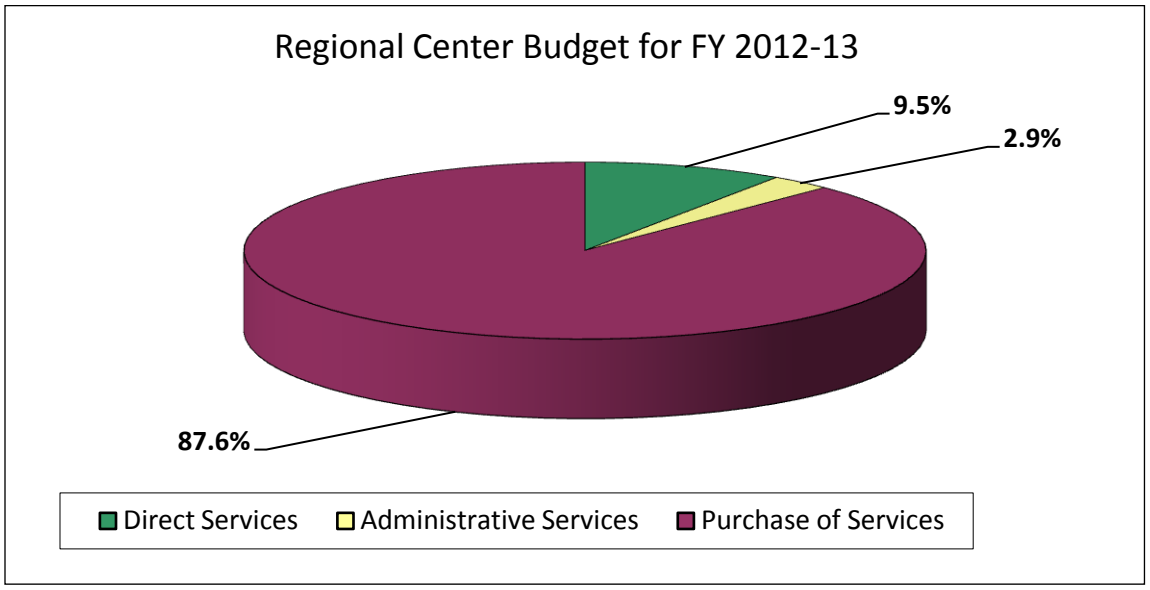


Direct services funded through the OPS budget include service coordination, assessment/diagnosis, individual program planning, consumer money/benefits management, clinical services, 24-hour emergency response, quality assurance,

advocacy, intake/assessment/referral, family support, training, special incident reporting/investigation, etc. Therefore, reductions in the regional-center OPS budget impact the provision of direct services to consumers. An attached publication prepared by Frank D. Lanterman Regional Center describes, in greater detail, the range of important direct services provided by regional centers.[iii]

The balance of the OPS budget (23.7%), funds all the regional centers' administrative costs and operating expenses, and represents just 2.9% of the total (OPS and POS) regional center budget.[iv] Chart 3 shows the OPS budget for the current fiscal year and how the funds are apportioned.

Chart 3



B. Budgeting and Allocation Methodology - Prior to 1979-80, each regional center developed its own staffing pattern and budget through negotiations with the Department of Developmental Services (DDS). Each staffing pattern was based on a program-budget methodology, and the budget-allocation methodology for compensation was based on projected actual salaries and benefits. While this approach addressed local variation and provided for flexibility and innovation, there was also argument for a less

subjective and more equitable method for allocating staffing resources to regional centers taking into account the size of the regional center (based on caseload) and the resources necessary to accomplish the regional centers' statutory and contractual mandates. This led to the development of the current methodology for funding the regional centers' personnel and related operational costs, which is commonly referred to as the "core staffing formula." This formula, developed in 1978, was crafted by DDS personnel based on their knowledge of existing regional center staffing patterns that had previously been approved by DDS, and other standards that were available at the time. For example, the case management ratio of one service coordinator to 62 consumers was based on what county welfare offices used for the Absent Parent Program to receive federal funding. This 1978 formula was arguably an improvement over the initial approach to budgeting and allocating OPS funding, but the formula was still an *ad hoc* creation developed without the benefit of the specialized study that such an important and complex statewide publicly-funded service system needed. There is no written analysis, justification, or documentation supporting the 1978 base formula, which is the same formula used today, except for some "add-ons" and minor changes.

The 1978 formula established specific positions, salaries, benefits, and operating expense assumptions/standards associated with the regional centers' mandates at the time. Salaries for various regional center staff positions were based on equivalent state classifications, with the assumption that as state salaries increased the formula salaries would increase at a similar rate. It also was assumed that benefit and operating expense assumptions would be periodically updated. See Attachment A for a copy of the current core staffing formula.

DDS and ARCA jointly develop the methodology for apportioning budgeted funds to the regional centers, with DDS retaining authority for the final allocation. The percentage of the total regional center funds budgeted to support regional center operations is 12.8 % in the current fiscal year, as shown in Chart 4. Charts 5 and 6 show the steady decline since FY 1988-89 in the proportion of operations funding compared to the total regional center budget.

CHART 4

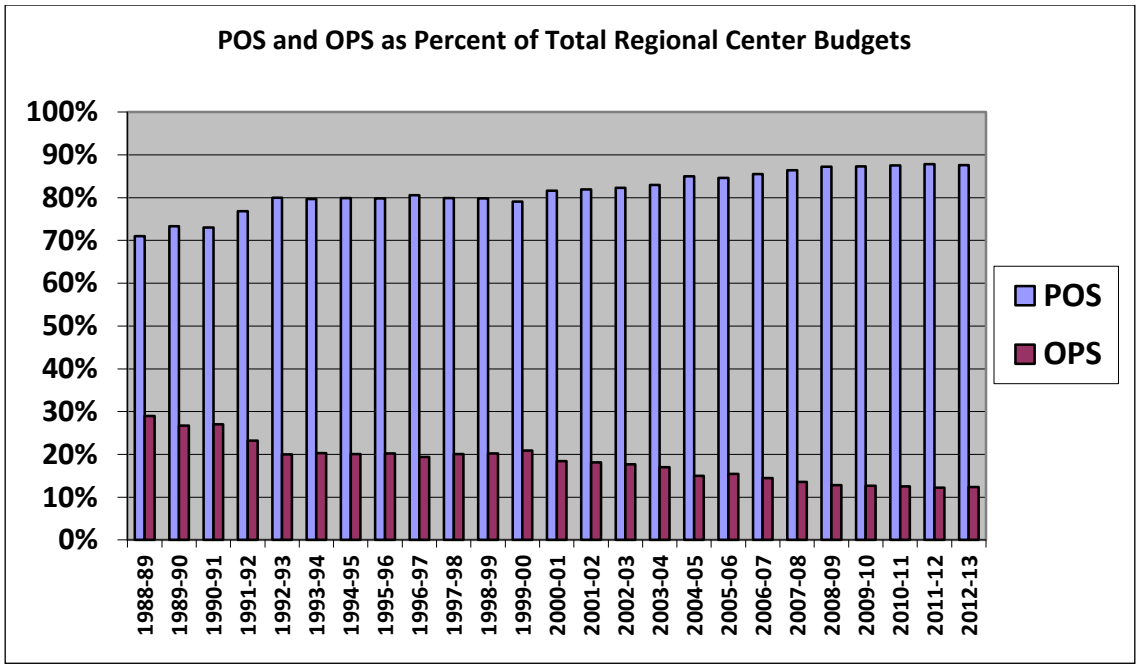
CATEGORY	FY 2013-14 MAY REVISION FY 2012-13 BUDGET *(Dollars in thousands)*	% OF TOTAL BUDGET
Operations	$537,415	12.8
Purchase of Services	3,647,976	86.7
Early Intervention and Prevention Programs	22,384	0.5
TOTAL	**$4,207,775**	**100.0**

CHART 5

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]			
FISCAL YEAR	**TOTAL BUDGET** *(Dollars in thousands)*	**% POS**	**% OPS**
1988-89	458,620	71.0	29.0
1989-90	558,237	73.3	26.7
1990-91	581,532	73.0	27.0
1991-92	647,799	76.8	23.2
1992-93	668,223	80.0	20.0
1993-94	740,511	79.7	20.3
1994-95	804,571	79.9	20.1
1995-96	905,416	79.8	20.2
1996-97	1,009,755	80.6	19.4
1997-98	1,145,438	79.9	20.1
1998-99	1,376,132	79.8	20.2
1999-00	1,584,201	79.1	20.9
2000-01	1,830,955	81.6	18.4
2001-02	2,027,554	81.9	18.1
2002-03	2,218,303	82.3	17.7
2003-04	2,397,486	83.0	17.0
2004-05	2,620,686	85.0	15.0

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]			
FISCAL YEAR	**TOTAL BUDGET** *(Dollars in thousands)*	**% POS**	**% OPS**
2005-06	2,784,773	84.6	15.4
2006-07	3,167,170	85.5	14.5
2007-08	3,512,929	86.4	13.6
2008-09	3,861,302	87.2	12.8
2009-10	3,886,591	87.3	12.7
2010-11	3,909,604	87.5	12.5
2011-12	3,958,227	87.8	12.2
2012-13	4,162,793	87.6	12.4

CHART 6



C. Factors Leading to OPS Underfunding – The factors that have led to the diminution of regional centers' operating capacity and to the current regional center OPS funding crisis fall within four primary categories: (1) actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in

operational workload, (2) actions imposing additional workload for which the regional centers received no additional - or inadequate - funding, (3) inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business, and (4) design flaws in the OPS formula. While not an exhaustive list, these factors, broken out by category, are as follows:

CATEGORY I: ***Actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in operational workload.***

- Eliminating Hospital Liaison Positions: The FY 1983-84 budget transferred case management services for consumers residing in state developmental centers from regional center employees to developmental center employees, and the regional center OPS budget was reduced accordingly. Prior to this time, regional centers were funded to regularly attend individual program plan meetings and to visit consumers residing in state developmental centers. At one time, regional centers were allocated one position for every 60 consumers residing in the developmental centers. This allocation was later changed to one position for every 120 consumers. In FY 1983-84, regional center staffing for state developmental center consumers was eliminated. A small number of similar positions (one position for every 400 developmental center consumers) were subsequently reestablished in the core staffing formula and continue to the present. This minimal allocation, however, did not compensate regional centers for the workload they continue to incur for state developmental center consumers, including the significant probate and criminal court demands developmental center residents generate. In FY 2009-10, as a result of the settlement in the Capitol People First, et. al. v. Department of Developmental Disabilities (DDS), funding was restored to provide a caseload ratio of one position for every 66 consumers residing in the developmental centers.

- Extending Regional Center Assessment Timelines: Regional centers have mandated timelines for completing their assessment of prospective consumers and for developing an individual program plan or individualized family service plan for those found eligible for services.[vi] The timeline for completing the assessment phase

of the process for consumers over age three has intermittently been extended from 60 to 120 calendar days to justify reducing the regional center OPS budget. This change was first enacted in FY 1992-93 through an urgency statute (Senate Bill 485, Chapter 722, Statutes of 1992) which sunset July 1, 1996. This action was implemented again in FY 2002-03 and, through subsequent legislative actions, has continued into the current fiscal year, and became permanent in FY 2008-09. The savings associated with this action derive from the reduced number of regional center clinical personnel needed for performing the required assessments. The justification for the estimated savings was valid the first year of implementation, but is not valid beyond the first year because intake workload is independent of mandated timelines. As one researcher observed, *"The consumer requires the same services and total staff time whether those services are spread over one, two or four months. The required time frames for assessment affect resource requirements only when they change, increasing or decreasing backlog. When time frame mandates do not change, the equivalent to one month's workload must be completed each month to keep backlog constant as a new set of intake cases arrive."*[vii] Thus, this policy change amounts to a funding reduction since the basic workload requirements remain after the first year.

- Imposition of Unallocated OPS Budget Reductions and Developing/Implementing Expenditure Plans: Unallocated reductions are reductions or offsets to a program's budget that are not specific to, or earmarked against, an individual program or line item. Such reductions are applied to, or offset, the bottom line of the budget. The budget for regional center OPS has sustained numerous unallocated reductions over the years, some of which have been restored and others not. The first unallocated reduction in the regional centers' OPS budget occurred in FY1982-83 ($2.2 million). Budget Act language required DDS to establish expenditure priorities for regional centers to ensure they maintained expenditures within the amount budgeted.[viii] These DDS-developed priorities for controlling costs were invalidated by the state Supreme Court in their 1985 ruling in *Association for Retarded Citizens v. Department of Developmental Services*.

The next unallocated reduction occurred in FY 1991-92. This reduction was followed by unallocated reductions in each fiscal year thereafter through 1995-96. Unallocated reductions were again instituted in FY 2002-03, 2003-04, and 2004-05. Regional centers achieved their OPS budget unallocated reduction target in FY 1991-92 and following through a variety of means including, but not limited to:

- Increasing service coordinator-to-consumer caseload ratios
- Reducing qualifications for new service coordinator employees
- Employee layoffs
- Temporary regional center closures of seven to fourteen days annually with the provision of only on-call emergency services
- Relinquishing money management or representative payee services for consumers receiving SSI/SSP benefits
- Reducing work hours
- Furloughing employees
- Reducing employee training
- Increasing employees' benefit premiums
- Renegotiating lease/rental costs
- Consolidating/closing offices
- Contracting out additional services
- Reducing travel, communication, consultant, legal, and other general administrative expenses
- Stopping hiring
- Discontinuing cost-of-living/salary adjustments

The regional centers' proposals for achieving the required reductions were incorporated into expenditure plans that DDS was required to review and approve, as appropriate.

Another round of reductions to regional center budgets began again in 2009 with the passage of ABX4 9 and continued through 2012. Though many of these budget

reductions used euphemisms such as “cost containment,” “operational efficiencies,” and “General Fund savings,” they were, in effect, unallocated reductions.

Some of these reductions were temporary, in the guise of across-the-board “payment reductions” which began in February 2009 as a 3% payment reduction, was increased to 4.25% in July 2010, and then reduced to 1.25% in July 2012. These reductions came to an end on July 1, 2013.

Unallocated reductions made to the regional center OPS budget since FY 1991-92 that continue to reduce regional center budgets in the current year and future years amount to $44.0 million.[ix] This is an effective budget reduction of 7.6%. These reductions are:

- Change in Intake and Assessment timeline $4.5 million
- FY 2001-02 unallocated reduction $10.6 million
- FY 2004-05 “Cost Containment” $6.0 million
- FY 2009-10 “Savings Target” $14.1 million
- FY 2011-12 “Cost Containment” $3.4 million
- FY 2011-12 unallocated reduction $5.4 million

<u>Category II</u>: ***Actions imposing additional workload for which the regional centers received no additional - or inadequate - funding.***

Numerous legislative actions since the early 1980s have placed significant unfunded requirements upon regional centers. Also, many other new requirements have been added, with some funding attached, but frequently the funding is insufficient to comply with the new requirements. Since the adequacy of funding may be seen by some as a disputable matter, the following identify only some of the more significant unfunded requirements or mandates that have been imposed.

- <u>Managing/Implementing the New Uniform Fiscal System</u>: During 1984, DDS implemented the statewide Uniform Fiscal System to provide for uniform accounting procedures and centralized collection of client and fiscal data. There were numerous

implementation issues and unfunded workload related to maintaining this new system.

- Performing New Vendorization Activities: DDS delegated additional vendorization workload to regional centers in FY 1985-86 through the issuance of the 'Vendor Procedures Manual.' New workload involved regional centers reviewing and approving vendor applications, and reviewing rate applications for specified programs before submission to DDS for rate setting.

- Following Up on Specialized Residential Service Facility Reviews: During FY 1985-86, DDS required the regional centers to follow up on DDS evaluations of specialized residential service facilities. Regional centers were required to absorb this additional workload.

- Change to Person Centered Planning: Passage of Senate Bill 1383 in September 1992 (effective January 1, 1993), mandated a new approach to developing individual program plans for regional center consumers. This new approach, called person centered planning, moved away from the traditional approach to service planning, guided by the professionals in the interdisciplinary team, to one where consumers and families assumed a primary role in the planning process, and where the needs and preferences of consumers and families were given much greater consideration. While this approach is preferable, developing an individual program plan using a person centered planning approach takes much longer than using the traditional approach, yet regional centers were not provided any additional resources to accommodate this increased workload.

- Administering Vouchers: In 1991, the Department adopted new regulations establishing a voucher mechanism for paying for specified services. This new approach gave families and adult consumers a direct role in procuring nursing, day care, respite, transportation, diapers and nutritional supplements. While beneficial for many who choose to obtain their services through this purchasing mechanism,

the processing of billings and payments for individual families is very staff-intensive, which includes training family members on record keeping and payroll tax requirements, and for which regional centers received no additional resources to perform the increased workload.

- Collecting and maintaining information on consumers' potential eligibility for Old Age Survivors Disability Insurance and referring such individuals to the Social Security Administration and conducting triennial continuing disability reviews. The law also required that individuals residing out of home be reviewed for such eligibility at the time of every review [Wel. & Insti. Code §4657 and §4658].

- Maintaining an emergency response system that must be operational 24 hours per day, 365 days per year [Wel. & Insti. Code §4640.6(b)].

- Annually preparing and submitting service coordinator caseload ratio data to DDS [Wel. & Insti. Code §4640.6(e)].

- Having or contracting for expertise in the following areas [Wel. & Insti. Code §4640.6(g)(1) through (6)]:
    1. Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.
    2. Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.
    3. Family support expertise to assist the regional center in maximizing the effectiveness of supports and services provided to families.
    4. Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supported living arrangements.

5. Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.
6. Quality assurance expertise to assist the regional center in providing the necessary coordination and cooperation with the Area Board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.

- Employing at least one consumer advocate who is a person with developmental disabilities [Wel. & Insti. Code §4640.6(g)(7)].

- Annually conducting four monitoring visits, of which at least two are unannounced monitoring visits, of every licensed long-term health care facility, licensed community care facility, and Adult Family Home Agency home [Wel. & Insti. Code §4648(a)].

- Adding the Adult Family Home Agency program as a new living option and requiring regional centers to engage in specific activities related to selecting, monitoring, and evaluating such programs [Wel. & Insti. Code §4689.1].

- Contracting annually with an independent accounting firm for an audited financial statement, including reviewing and approving the audit report and accompanying management letter, and submitting this information to DDS before April 1 of each year [Wel. & Insti. Code §4639

- During the individual program planning process, reviewing and documenting each consumer's health status, including his/her medical, dental, and mental health status and current medications [Wel. & Insti. Code §4646.5 (a)(5)].

- Developing and updating every six months, as part of the individual program plan, a written statement of the regional center's efforts to locate a living arrangement for minor children placed out of the family home for whom the parents or guardian have requested closer proximity to the family home [Wel. & Insti. Code §4685.1 (a)].

- Developing, implementing, and reviewing annually a "memorandum of understanding" with each (as appropriate) county mental health agency to perform specified activities related to planning, coordinating, and providing services to dually-diagnosed consumers [Wel. & Insti. Code §4696.1].

- Annually preparing and submitting to DDS: (1) a current salary schedule for all personnel classifications used by the regional center, and (2) a listing of all prior fiscal year expenditures from the OPS budget for all administrative services, including managerial, consultant, accounting, personnel, labor relations, and legal services [Wel. & Insti. Code §4639.5].

- Transferring responsibility for conducting initial consumer/family complaint investigations, as required pursuant to Wel. & Insti. Code §4731, from the clients' rights advocate to the regional center director [Wel. & Insti. Code §4731(b)].

- Responsibility for monitoring and paying Habilitation Services Program providers. This $150 million program, which was transferred from the Department of Rehabilitation to DDS, involves about 500 providers.

- Implementing the Family Cost Participation Plan (FCPP) and the Annual Family Program Fee (AFPF), wherein staff assesses fees to families based on specific criteria [Wel. & Insti. Code §4783 and §4785 respectively].

- Every two years screening all vendored service providers against federal and state databases to ensure vendors have not been disqualified from participating

in the Home and Community Based Services (HCBS) Waiver program [Wel. & Insti. Code §4648.12].

- Implementing electronic billing for all vendored service providers [Govt. Code §95020.5 and Wel. & Insti. Code §4641.5].

- Requiring regional centers to post specific information on their internet websites [Wel. & Insti. Code §4629.5].

- Responsibility for reviewing audit reports of medium-sized and large vendors conducted by independent certified public accountants [Wel. & Insti. Code §4652.5].

- Developing Transportation Access Plans for certain consumers [Wel. & Insti. Code §4646.5(a)(6)].

- Completing comprehensive assessments for residents of developmental centers and consumers placed in settings ineligible for Federal Financial Participation and developing appropriate resources in the community [Wel. & Insti. Code §§4418.25(c)(2)(A), 4519(a), and 4648(a)(9)(C)(iii)].

- Verifying individual or family income in order to determine a consumer's eligibility for financial assistance with funding health insurance copayments and coinsurance [Wel. & Insti. Code §4659.1].

- Changing accounting firms to ensure that no accounting firm completes a required financial audit more than five times in ten years [Wel. & Insti. Code §4639(b)].

- Complete a standardized questionnaire upon a consumer's entry into supported living services and at each IPP review thereafter [Wel. & Insti. Code § 4689(p)(1)].

- Completing transition plans for all regional center consumers residing out-of-state and conduct statewide search for in-state services and development of appropriate services as needed [Wel. & Insti. Code § 4519(e)].

- Notifying the Client Rights Advocate of IPP meetings for developmental center residents [Wel. & Insti. Code § 4418(c)(2)(D)], IPP meetings for consumers to be placed in an IMD [Wel. & Insti. Code § 4648(a)(9)(C)(iv)] or who are residing in an IMD [Wel. & Insti. Code § 4648(a)(9)(C)(v)], and of writs of habeas corpus [Wel. & Insti. Code § 4801(b)].

- Completing referrals to Regional Resource Development Projects and Statewide Specialized Resource Service.

- Increased need to do Health and Safety waiver requests due to the freezing of service provider rates.

Category III: ***Inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business.***

- Failure to Update Salaries in the Core Staffing Formula

  The model for budgeting regional centers' personnel costs is formula driven. The model calculates the number and type of personnel or positions theoretically needed for a regional center to comply with its mandated obligations. A position's salary in the formula is linked to the mid-range state salary for the equivalent state position based on when the regional center position was added to the formula. Until FY 1991-92, whenever state employees received a cost-of-living adjustment, the formula was updated in the formula to maintain salary equivalency with comparable state positions. This policy of indexing regional centers' personnel budget increases to state employee cost-of-living adjustments continued through FY 1990-91. In FY 1991-92, the policy changed when the

state ceased providing regional centers cost-of-living adjustments for their personnel costs. **This policy change, which has continued through the current fiscal year, is the action that has impacted the OPS budget most significantly**.

Illustrating the fiscal impact of this policy change is the regional center "Revenue Clerk" position, which is linked to the state equivalent position classification of "Accounting Technician." The annual mid-range salary for the state Accounting Technician position is currently $35,082, whereas the formula uses an annual mid-range salary of $18,397, which reflects the Accounting Technician annual mid-range salary as of FY 1990-91. Based on caseload and other factors, the budgeting formula calculates the number of positions a regional center needs to perform the specified function(s) for which the Revenue Clerk positions are allocated. The number of positions is then multiplied by the salary in the formula. In this instance, the salary remains equivalent to the state's Accounting Technician in FY 1990-91, or $18,397, which is barely half of the current annual mid-range salary for the state Accounting Technical position. Except for new positions added to the formula since it was developed, and adjustments made in the late 1990s to service coordinator salaries in response to federal audit issues, salaries in the formula have not been adjusted for 23 years. This has the same impact of not receiving a cost-of-living adjustment for 23 years.

The impact of this policy change is enormous, resulting in underfunding the OPS budgeting formula by about $288 million annually. Consequently regional centers are budgeted for their staff at only 58% of what they would be if the core staffing salaries had kept up with inflation.

- <u>Failure to Fully Fund Mandated Caseload Ratios</u>

  According to Wel. & Insti. Code § 4640.6, regional centers are required to maintain certain caseload ratios. For consumers on the HCBS Waiver or in Early

Start, the mandated caseload ratio is one Client Program Coordinator (CPC) for every 62 consumers and for those not on the HCBS Waiver or in Early Start, the required ratio is one CPC for every 66 consumers. However, due to the drastic underfunding of the core staffing formula, as discussed above, it is impossible for regional centers to hire sufficient CPCs to meet these ratios. According to the Core Staffing Schedule in the FY 2013-14 regional center budget, regional centers should have 4,148 CPCs to meet the mandated caseload ratios. However they are funded at only $34,032 per CPC. The actual mid-range salary for CPCs that the regional centers pay is $46,121. At that salary level, the regional centers can afford only 3,061 CPCs, over a thousand less than the formula indicates. This means the average caseload ratio regional centers can afford is one CPC for every 87 consumers. Had the CPC salaries in the core staffing formula kept pace with State salary increases, the budgeted salary would be about $50,340, and if it had kept pace with the Consumer Price Index it would be about $61,200.

The ability of regional centers to hire a sufficient number of CPCs to meet the required caseload ratios is further hindered by the unallocated budget reductions (discussed above), the imposition of a salaries savings factor and a fringe benefit rate of only 23.7% (discussed later).

Category IV: *Design flaws in the OPS formula.*

The existing core staffing formula was developed when the regional center operating environment was far different. In 1978, regional centers were relatively small organizations, their mandates far fewer, and funding streams less diverse. Regional centers have grown tremendously in size and complexity, and their responsibilities have expanded greatly, yet the formula has remained much the same. Those who developed the formula never contemplated a regional center managing, on average, over $196 million annually in state and federal funds, which is a greater amount than the entire regional center budget was for FY 1979-80, nor did they anticipate the average center having about 350 employees.

Specific examples of some of the deficiencies in the core staffing formula include the following:

- The organizational model embodied in the formula did not envision regional centers with hundreds of employees, therefore, staffing for the management and supervision structure for such large organizations is not provided. This problem is exacerbated at large regional centers. The formula does recognize the need for more of certain positions where the number of consumers drives the workload significantly; however, there are other positions, such as the Human Resources Manager and the Training Officer, that every regional center is allocated only one position, regardless of size. Also, large regional centers have need of additional senior and middle management personnel who are not provided for in the formula.

- The "equivalent" state positions used in the formula were determined apart from any review or input from regional centers and, therefore, lack comparability with actual regional center position responsibilities. This lack of comparability has only increased over time as regional centers have grown in size and complexity. This specific problem was identified in a 1984 DDS/ARCA-sponsored study performed by Cooperative Personnel Services, which found that the positions used in the formula were undervalued by approximately 12% on average at that time.

- The formula imposes a 5.5% salary savings requirement on all regional center positions, except for service coordinator positions, where the salary savings is 1%. The imposition of a salary savings requirement fails to account for the need to fill vacancies through overtime or contract personnel, or for the additional costs related to turnover (e.g., advertising, recruiting, and training of staff). Due to mandates and contract requirements, few regional center responsibilities can simply be postponed or neglected.

- In many instances, the use of “one per” positions (e.g., allocating funding for certain positions to every regional center regardless of size and/or programs and/or large and widespread geographic boundaries) fails to generate the appropriate number of personnel required for those positions where regional center size, demographics, and/or number of vendored programs drive the workload. Again, this reflects an assumption in the original formula, which presumed each regional center would serve approximately the same number of consumers in generally the same manner, which, at the time, were about 2,000 per center. Today the largest regional center serves about 22,000 active and high-risk consumers, whereas the smallest center serves about 3,000 consumers in a geographically large and widespread area.

  One example is the Resource Developer. Each regional center is budgeted for only one regardless of the number of consumers served or the number of service providers vendored by the regional center.

- The formula uses a standard 23.7% figure for budgeting total fringe benefits. This figure has not been adjusted to account for increases in such areas as workers’ compensation, health benefits, FICA, etc. By comparison, the current fringe benefit percentage used by DDS for its Headquarters personnel is 41.6%.[x]

- The state equivalent positions used in the formula are budgeted at the midpoint of what is typically a five-step state salary range. This methodology results in underfunding for every employee who remains with the regional center more than three years since there is no allowance for seniority or merit salary adjustments after the third year of service (assuming the individual was initially hired at the lowest step of the salary range).

- The formula does not recognize or account for the very significant regional variations in prevailing salary levels.

- The amount provided for regional center operating expenses and equipment per position has not been updated since FY 1985-86, when it was set at the amount used by DDS for its Headquarters employees.

The core staffing formula, therefore, suffers from a variety of deficiencies which, when combined with all the other the issues noted above, has created an enormous OPS budgetary shortfall that continues to worsen.

D. History of Efforts to Remedy OPS Underfunding - Concerns about underfunding in the regional center OPS budget are not new. ARCA has given this matter considerable attention over the years. Unfortunately, these efforts have yielded little success. The following summarizes the most significant past efforts to address the inadequacies of the OPS budgeting methodology:

1. 1981 – *Staffing Standards Task Force*. ARCA forms a Staffing Standards Task Force to *"study and prepare a 'core staffing' formula that more closely approximates the Regional Center staff responsibilities as directed in law and legal contract."* The Task Force surveys regional centers, reviews current regional center activities, and develops a "core staffing" plan. ARCA adopts the Task Force report and forwards it to DDS. DDS takes no action due to budgetary concerns.

2. 1983 – *Personnel Task Force Report*. ARCA establishes a Personnel Task Force to (1) pursue a core staffing study, and (2) coordinate a study comparing the state's classification and pay plan with that of the regional center core staffing formula. Cooperative Personnel Services (at that time an entity within the State Personnel Board) conducts the comparison classification study and issues its report in February of 1984. The report finds that the regional center position salaries lag the state equivalent positions by 12.4%. The Task Force develops a recommended staffing allocation formula reflecting the resources needed for regional centers to comply with their contractual and statutory obligations. The Personnel Task Force releases its report in February 1984, including a copy of the CPS study as an

appendix. DDS, while sympathetic, is not able to gain support within the Administration to implement the report's recommendations.

3. 1989 – *Personnel Task Force Report*. Another ARCA Personnel Task Force convenes and: (1) reviews and updates information on current regional center mandates, (2) engages Cooperative Personnel Services to revise their prior compensation study with some updates, and (3) develops a report that includes a historical perspective, a task analysis for each position in the core staffing formula, a comprehensive model staffing and allocation plan using a *"slightly less than average regional center"* construct, and findings and recommendations. The report is issued in January 1990. The Cooperative Personnel Services study finds that regional center positions are underfunded by approximately 10% in comparison to comparable state positions. The ARCA Board of Directors approves a motion by the Executive Committee to prepare and submit an Executive Summary of the Task Force report to Senator Dan McCorquodale to be considered in the Senate Resolution 9 hearings. The Executive Summary and a copy of the second study conducted by Cooperative Personnel Services are transmitted to Senator McCorquodale and key legislative committee consultants. No action is taken.

4. 1999 - *Citygate Associates Study* – DDS, acknowledging serious flaws in the core staffing formula and concerned about OPS underfunding, engages a contractor to *"Identify the . . . staff that will enable Regional Centers to meet their state and federal mandates and are consistent with good business practices."* The Legislature, in the FY1998-99 Budget Act, adopts control language requiring DDS to *". . . provide the Fiscal and Policy Committees of the Legislature with the Findings of the Regional Center Core Staffing Study by no later than March 1, 1999. This study is to address the type of classification, number, qualification, and compensation required for Regional Centers to meet their state and federal mandates and to be consistent with good professional and business practices."*

A contract is awarded to Citygate Associates in June 1998 and, with two subsequent contract amendments, the state expends $402,000 for the study. ARCA, the Department of Finance, and DDS oversee the study design and project findings. Citygate's study methodology includes a qualitative and quantitative analysis, including: ten regional forums with regional center line staff representing the range of regional center personnel; four regional forums for vendors, consumers and family members; site visits to five regional centers; background interviews with key constituents; a research literature review; a survey of regional centers; review of the draft report by regional center teams representing a cross-section of regional center personnel; and three public hearings. Citygate delivers a final report to DDS in September 1999 unveiling a new methodology for budgeting regional center staffing and operating expenses. The report identifies numerous problems with the existing budgeting formula, resulting in 24% less funding than needed to appropriately meet state and federal mandates.

The Legislature adopts additional Budget Act language in FY 1999-2000 requiring DDS, by December 15, 1999, to *". . . make recommendations to the Legislature and the Governor regarding the core staffing formula used to allocate operations funding to regional centers. These recommendations shall include consideration of, and public comments related to, the Regional Center Core Staffing Study, and shall include, but not be limited to, all of the following: (1) Salary and wage level for positions deemed necessary to retain and maintain qualified staff. (2) Regional center staff positions that should be mandated. (3) Staffing ratios necessary to meet the requirements of this chapter, including a service coordinator-to-consumer ratio necessary to appropriately meet the needs of consumers who are younger than three years of age and their families. (4) Funding methodologies. (5) Indicate the impact of staffing ratios implemented pursuant to subdivision (c) . . ."*

DDS uses the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal is supported within the

Administration, but is not included in the Governor's budget because of a severe economic downturn.

5. 2001 – *ARCA Position Paper.* ARCA prepares and transmits a position paper to the director of DDS detailing regional center OPS and POS budget issues. The paper is based on a survey of all 21 regional centers. The paper and attending transmittal letter highlight the OPS underfunding issue confronting the centers and identifies the need for "serious and immediate attention." Again, no action is taken.

E. Changes in the Budgeting Formula - The original "core staffing formula" has been adjusted intermittently throughout the years, as shown in the next chart. Not included are increases associated with Community Placement Plan (CPP) efforts to move people from state developmental centers into the community, since this is a state priority that has generally been well-funded. The following are non-CPP related changes since FY 1990-91 that resulted in additional OPS funding and the reasons for these increases:

CHANGES IN THE OPERATIONS BUDGETING FORMULA

YEAR	CHANGE	FUNDING (Millions)	REASON
90-91	Funding to perform activities required by the Sherry S./Violet Jean C. Court cases.	$1.0	Court-required workload.
97-98	Establishing 21 regional center clinical teams to enhance the centers' clinical capacity.	6.1	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
97-98	Requiring regional centers to conduct quarterly monitoring for all consumers living out of home.	14.8	Same as above
98-99	Updating budgeted salaries for quarterly monitoring staff, clinical teams, and case management staff serving consumers placed from developmental centers.	5.0	Same as above
98-99	Updating base staffing levels to ensure	3.5	Same as above

YEAR	CHANGE	FUNDING (Millions)	REASON
	sufficient staffing for performing quarterly monitoring visits.		
98-99	Establishing 14 additional regional center clinical teams.	4.5	Same as above
98-99	Increasing monitoring frequency of consumers with health conditions living in CCFs. Regional center are provided addition staff for new activities.	5.3	New DSS Title 22 regulatory requirements.
98-99	Reducing CPC caseloads to 1:62 (included reduction of CPC salary savings requirement; updating CPC salaries; restoration of unallocated reduction for CPCs; and funding other essential positions). (Half-year funding)	27.9	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
99-00	Additional funds to fully implement the above reduction of CPC caseloads to 1:62.	27.9	Same as above
98-99	Establishing a consumer complaint process in statute. Regional centers each provided ½ position for new workload.	0.7	Legislation (SB 1039) establishing a consumer complaint process, i.e., Wel. & Insti. Code 4731.
98-99	Fund Essential Regional Center Positions – Information Systems manager, Personal Computer Systems Manager, Training Officer, Special Incident Coordinator, Vendor Fiscal Monitor, Human Resources Manager, and Information Systems Assistant (half-year funding)	6.7	Fund essential positions previously not included in the core staffing formula
99-00	Additional funds to fully implement the above new positions.	6.7	Same as above
99-00	Performing health status reviews of consumers during a part of the IPP process.	3.2	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
00-01	Establishing 1:45 maximum caseload ratios for service coordinators for consumers placed out of state developmental centers.	0.6	Same as above
01-02	Implementing a statewide risk management system, including regional center risk management committees.	6.7	Same as above
02-03	Establishing Federal Program Coordinators and providing unfunded rent relief.	15.2	State initiative to increase and maintain federal financial participation.
03-04	Establishing Federal Compliance Specialists and fiscal/contract documentation staff.	4.4	Same as above
03-04	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	1.4	State initiative to increase federal financial participation.
03-04	Complying with requirements of the federal	1.4	Congressional enactment

YEAR	CHANGE	FUNDING (Millions)	REASON
	Health Insurance Portability and Accountability Act (HIPPA)		of HIPPA legislation.
04-05	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	2.8	State initiative to increase federal financial participation.
04-05	Funding for regional center administrative activities associated with implementing the Family Cost Participation Program.	.6	Enactment of legislation establishing the Family Cost Participation Program.
05-06	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.8	State initiative to increase federal financial participation.
06-07	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.3	Same as above
07-08	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.1	Same as above
06-07	Funding for expansion of Autism Spectrum Disorder Initiative	1.7	State initiative to better serve consumers with autism spectrum disorder
07-08	Additional funds to implement the expansion of the Autism Spectrum Disorder Initiative.	1.8	Same as above
08-09	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	.9	State initiative to increase federal financial participation.
09-10	Fund additional case managers to participate in IPP meetings of consumers residing in state developmental centers	3.1	Pursuant to the Capitol People First lawsuit settlement

The above chart illustrates that, with a few relatively minor exceptions, all the positive adjustments to the OPS budget since FY1990-91 have been driven by actions related to preventing/minimizing the loss of federal funding, and initiatives to increase federal funding. While helpful, these increases or positive adjustments are dwarfed by the losses suffered in the OPS budget highlighted in the previous section on *Factors Leading to OPS Underfunding*.

III. THREAT TO FEDERAL FUNDING

In a 1992 oversight hearing before a Senate Budget Subcommittee, the DDS Director testified that *"the Department believes that regional centers have sustained the most serious and damaging budget reductions of all entities in the developmental services system. The Department is concerned that two years of unallocated reductions to*

regional centers' operations budget has severely impaired their ability to meet their existing statutory and contractual requirements . . . [and that the reduction had] . . . reduced [the] ability of the regional centers to monitor client services and care. The Department is also concerned that the diminished ability of regional centers to monitor the health and safety of vulnerable clients placed in residential care facilities, particularly for clients who do [not] have an involved parent, may lead to an increase in health and care problems."[xi] The concerns expressed by Mr. Amundson were prescient and later confirmed when noted in a December 2007 Department report to the Legislature. In this report, the Department stated that, *"In 1997, the federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services (CMS)) conducted its first major review of the state's Waiver and found serious deficiencies . . . In response to these findings, the state negotiated with the federal government to implement a series of initiatives necessary to continue in the Waiver program . . . The new initiatives were designed as permanent infrastructure improvements targeted at improving the overall quality of the service system. The federal government, however, froze Waiver enrollments as of December 1997 until the state demonstrated each regional center had implemented these changes. . .* ***The cumulative impact of this enrollment freeze cost the state an estimated $933 million in lost federal funds****.*[xii] [Emphasis added] *This significant funding loss underscores the importance of meeting federal quality assurance standards in the developmental services system lest the savings achieved through cost-containment measures is dwarfed by subsequent losses in federal reimbursement."*[xiii] The CMS freeze on enrolling new people in the Waiver was not fully lifted until January 2004, or nearly six years later. Due to the Department's and the regional centers' successful efforts in recent years to significantly increase federal funding, the state now has considerably more federal funding at stake should sanctions again be imposed.

One of the key issues identified by CMS during its review were the inordinately high caseloads of regional center service coordinators, which is a situation directly related to insufficient resources, since service coordinators, and their associated costs, comprise about 60% of the entire regional center OPS budget.[xiv] The CMS review noted that

"Case management activities are deficient . . ." and that there *". . . is a decreasing level of expertise and experience among case managers caused by high turnover rates and high case loads."*[xv] The state's corrective action plan to CMS involved setting a maximum limit on Waiver caseloads and providing additional funding for regional center operations. However, regional centers now find themselves in perhaps an even more compromised position, with respect to caseload ratios and the ability to ensure consumers' health and safety, than when CMS conducted their review in 1997. For example, DDS's most recent caseload ratio survey shows that two-thirds of the regional centers are not complying with at least one or more of their statutorily required (Wel. & Insti. Code 4640.6) caseload ratios, and over one-half of the regional centers cannot meet the specific caseload ratio requirement for consumers enrolled in the Waiver.[xvi] This requirement is not only specified in statute, but it is included in the state's approved application for the Waiver. Thus, the state is not fully complying with an assurance to the federal government upon which the receipt of federal funding was predicated.

The seriousness of this situation becomes all the more evident when one considers that state law requires that service coordination be the ". . . *highest priority*,"[xvii] with respect to regional center staffing patterns. Many regional centers' inability to meet even this statutorily prioritized service delivery requirement, despite their best efforts, suggests something about the severe resource issues that exist in other important regional center operational areas.

IV. CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[xviii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to

severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has “accepted a responsibility” is directly threatened.

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17. "Regional Centers' Budget History," Department of Developmental Services, Budget Section, April 8, 2008.

ENDNOTES

[i] Wel. & Insti. Code §4621.5

[ii] Wel. & Insti. Code §4501.

[iii] "Regional Center Operations: Unique Value-Added Services," Frank D. Lanterman Regional Center, October 13, 2008.

[iv] Based on the FY 2012-13 budget data prepared by the Department of Developmental Services, Estimates Section, May 14, 2013.

[v] These data reflect (a) budgeted amounts per the Budget Act for FY 1988-89 through 1991-92, (b) actual expenditures for OPS and POS for FY 1992-93 through 1999-00 per the Department of Developmental Services' budget charts entitled *"Regional Centers Budget History (dated May 4, 2004*)", (c) actual budget allocations of OPS and POS to the regional centers for FY 2000-01 through 2011-12, and (d) OPS and POS budgets for FY 2012-13 per the 2013 May Revision of the 2013-14 Budget.

[vi] Wel. & Insti. Code Sec. 4642 and 4643, and Government Code Sec. 95016.

[vii] "Regional Center Core Staffing Study – Final Report," prepared by Citygate Associates for the California Department of Developmental Services, September 1999, p. III-8.

[viii] Assembly Bill 21, the Budget Act of 1982, Item 4300-101-001, Provision 8.

[ix] Department of Developmental Services, Regional Centers 2013-14 May Revision, May 14, 2013.

[x] Department of Developmental Services, Developmental Centers 2013 May Revise.

[xi] Dennis Amundson, *Testimony for the Oversight Hearing of the Senate Budget Subcommittee #3 on Health, Human Services and Labor, Department of Developmental Services*, November 5, 1992, p. 18 and 22.

[xii] "Estimate of Lost Federal Financial Participation Due to CMS Freeze on Enrollments," Department of Developmental Services, Community Operations Division, Federal Programs Section, October 23, 2007.

[xiii] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 29.

[xiv] Based on the FY 2008-09 May Revision Core Staffing. Included in the 60% figure is all funding budgeted for service coordinators, service coordinator supervisory and support staff, and proportional funding for office rent and other operating expenses and equipment.

[xv] "Compliance Review of California's Home and Community Based Services Waiver Program for the Developmentally Disabled – Control Number 0129.91," Health Care Financing Administration, Regional IX, January 12, 1998, p. 27.

[xvi] Regional center caseload ratio surveys of March 2013.

[xvii] Wel. & Insti. Code §4640.6 (a).

[xviii] Wel. & Insti. Code §4501.

ATTACHMENT A

CORE STAFFING FORMULA

ATTACHMENT A

Attachment A
CORE STAFFING - BY 2013-14
Comparison of the 2013-14 Governor's Budget to the 2013 May Revision

	Governor's	May Revision			
		Budgeted			
	Budget	Positions	Salary	Cost	Difference
I. CORE STAFFING FORMULA					
A. PERSONAL SERVICES					
1. DIRECT SERVICES					
a. Clinical					
(1) Intake and Assessment					
(a) Physician	$10,598,533	**133.22**	**$79,271**	**$10,560,483**	-$38,050
(b) Psychologist	11,165,020	**266.43**	**41,754**	**11,124,518**	-40,502
(c) Nurse	4,969,763	**133.22**	**37,171**	**4,951,921**	-17,842
(d) Nutritionist	3,760,981	**133.22**	**28,130**	**3,747,479**	-13,502
(2) Clinical Support Teams					
(a) Physician/Psychiatrist	6,350,346	**69.00**	**92,034**	**6,350,346**	0
(b) Consulting Pharmacist	4,171,050	**69.00**	**60,450**	**4,171,050**	0
(c) Behavioral Psychologist	3,793,068	**69.00**	**54,972**	**3,793,068**	0
(d) Nurse	3,482,982	**69.00**	**50,478**	**3,482,982**	0
(3) SB 1038 Health Reviews					
(a) Physician	2,195,011	**22.12**	**92,034**	**2,035,792**	-159,219
(b) Nurse	5,618,201	**103.23**	**50,478**	**5,210,844**	-407,357
b. Intake / Case Management					
(1) Supervising Counselor (Intake) (1:10 Intake Workers in Item (2) below)	3,176,767	**82.74**	**38,036**	**3,147,099**	-29,668
(2) Intake Worker	26,333,950	**827.42**	**31,532**	**26,090,207**	-243,743
(3) Supervising Counselor (Case Management) (1:10 CPCs in Items (6) and (7) below)	22,073,797	**419.61**	**52,392**	**21,984,207**	-89,590
(4) Supervising Counselor (Capitol People First) (DC Case Management 1:10 CPCs)	242,592	**3.61**	**67,200**	**242,592**	0
(5) Client Program Coordinator (CPC), 1:66 DC Consumers Capitol People First	1,698,326	**36.12**	**47,019**	**1,698,326**	0
(6) CPC, 1:66 Consumers(Total Pop w/o DCs,CPP,ES)	66,394,390	**1,950.79**	**34,032**	**66,389,285**	-5,105
(7) CPC (Waiver, Early Start only), 1:62 Consumers	75,322,005	**2,197.06**	**34,032**	**74,770,346**	-551,659
(8) CPC, Quality Assurance for ARM	1,666,547	**48.25**	**34,032**	**1,642,044**	-24,503
(9) Supervising Counselor, DSS Incidental Medical Care Regulations (1:10 CPCs)	71,253	**1.36**	**52,392**	**71,253**	0
(10) CPC, DSS Incidental Medical Care Regs	515,541	**13.62**	**37,824**	**515,163**	-378
c. Quality Assurance / Quarterly Monitoring					
(1) Supervising Counselor	2,061,101	**40.08**	**52,392**	**2,099,871**	38,770
(2) CPC	13,387,168	**400.82**	**34,032**	**13,640,706**	253,538
d. Early Intervention					
(1) General					
(a) Prevention Coordinator	876,792	**21.00**	**41,752**	**876,792**	0
(b) High-Risk Infant Case Manager	856,905	**21.00**	**40,805**	**856,905**	0
(c) Genetics Associate	798,714	**21.00**	**38,034**	**798,714**	0
(2) Early Start / Part C					
(a) Supervising Counselor	1,142,670	**20.93**	**52,392**	**1,096,565**	-46,105
(b) CPC	7,423,740	**209.32**	**34,032**	**7,123,578**	-300,162
(c) Administrative and Clinical Support (see next page)					
e. Community Services					
(1) Special Incident Coordinator	1,100,232	**21.00**	**52,392**	**1,100,232**	0
(2) Vendor Fiscal Monitor	1,309,741	**21.88**	**50,844**	**1,112,467**	-197,274
(3) Program Evaluator	898,653	**21.00**	**42,793**	**898,653**	0
(4) Resource Developer	898,653	**21.00**	**42,793**	**898,653**	0
(5) Transportation Coordinator	898,653	**21.00**	**42,793**	**898,653**	0
(6) Administrative Services Analyst (SB 1039 Consumer Complaints)	449,327	**10.50**	**42,793**	**449,327**	0
(7) Developmental Center Liaison	226,695	**3.33**	**38,036**	**126,660**	-100,035
(8) Diversion	126,584	**4.00**	**31,646**	**126,584**	0
(9) Placement Continuation:					
(a) Supervising Counselor	6,287	**0.13**	**52,392**	**6,811**	524
(b) CPC (Supplement at 1:45 Consumers)	40,838	**1.34**	**34,032**	**45,603**	4,765
f. Special Incident Reporting (SIR)					
(1) Supervising Counselor	388,749	**7.40**	**52,392**	**387,701**	-1,048
(2) QA/CPC	2,525,855	**74.02**	**34,032**	**2,519,049**	-6,806
(3) Nurses	1,873,239	**37.01**	**50,478**	**1,868,191**	-5,048
g. Mediation					
(1) Clinical Staff	7,093	**0.11**	**64,484**	**7,093**	0
(2) Supervising Counselor	52,916	**1.01**	**52,392**	**52,916**	0
(3) CPC	17,356	**0.51**	**34,032**	**17,356**	0
h. Expansion of Autism Spectrum Disorders (ASD) Initiative					
(1) ASD Clinical Specialist	1,371,888	**21.00**	**65,328**	**1,371,888**	0
(2) ASD Program Coordinator	1,318,464	**21.00**	**62,784**	**1,318,464**	0
i. SUBTOTAL DIRECT SERVICES	**$293,658,436**	**7,669.41**		**$291,678,437**	-$1,979,999

Attachment A

CORE STAFFING, BY (continued)

	Governor's Budget	May Revision Positions	Budgeted Salary	Cost	Difference
2. ADMINISTRATION					
a. Executive Staff					
(1) Director	$1,279,698	**21.00**	**$60,938**	**$1,279,698**	$0
(2) Administrator	1,009,449	**21.00**	**48,069**	**1,009,449**	0
(3) Chief Counselor	986,643	**21.00**	**46,983**	**986,643**	0
b. Fiscal					
(1) Federal Program Coordinator (Enh. FFP, Phase I)	1,206,177	**21.00**	**57,437**	**1,206,177**	0
(2) Federal Compliance Specialist (Enh. FFP, Phase II)	4,221,241	**105.82**	**39,887**	**4,220,842**	-399
(3) Fiscal Manager	963,480	**21.00**	**45,880**	**963,480**	0
(4) Program Tech II (FCPP)	882,890	**24.21**	**36,468**	**882,890**	0
(5) Revenue Clerk	1,234,546	**60.82**	**20,617**	**1,253,926**	19,380
(6) Account Clerk (Enh. FFP, Phase II)	584,640	**21.00**	**27,840**	**584,640**	0
(7) Account Clerk	8,198,991	**444.05**	**18,397**	**8,169,188**	-29,803
c. Information Systems and Human Resources					
(1) Information Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(2) Information Systems Assistant	1,000,692	**21.00**	**47,652**	**1,000,692**	0
(3) Information Systems Assistant (SIR)	500,346	**10.50**	**47,652**	**500,346**	0
(4) Privacy Officer (HIPAA)	898,653	**21.00**	**42,793**	**898,653**	0
(5) Personal Computer Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(6) Training Officer	1,099,728	**21.00**	**52,368**	**1,099,728**	0
(7) Training Officer (SIR)	549,864	**10.50**	**52,368**	**549,864**	0
(8) Human Resources Manager	1,067,724	**21.00**	**50,844**	**1,067,724**	0
d. Clerical Support					
(1) Office Supervisor	489,867	**21.00**	**23,327**	**489,867**	0
(2) PBX/Mail/File Clerk	1,378,188	**63.00**	**21,876**	**1,378,188**	0
(3) Executive Secretary	1,148,490	**52.50**	**21,876**	**1,148,490**	0
(4) MD/Psychologist Secretary II	279,019	**11.06**	**23,388**	**258,671**	-20,348
(5) MD/Psychologist Secretary I	4,387,232	**199.83**	**21,876**	**4,371,481**	-15,751
(6) Secretary II	3,913,748	**166.77**	**23,388**	**3,900,417**	-13,331
(7) Secretary I	19,328,526	**1,023.64**	**18,757**	**19,200,415**	-128,111
(8) Secretary I (DC Case Management - Capitol People First)	210,834	**6.62**	**31,848**	**210,834**	0
e. SUBTOTAL ADMINISTRATION	**$59,616,354**	**2,452.32**		**$59,427,991**	**-$188,363**
3. TOTAL POSITIONS AND SALARIES (Item A.1.i. + Item A.2.e.)	$353,274,790	**10,121.73**		$351,106,428	-$2,168,362
a. CPCs	*168,476,225*			*167,846,293*	*-629,932*
b. All Other Staff	*184,798,565*			*183,260,135*	*-1,538,430*
4. Fringe Benefits					
a. CPCs 23.7%	**$39,928,865**			**$39,779,571**	-$149,294
b. All Other Staff 23.7%	**43,797,260**			**43,432,652**	-364,608
c. Total Fringe Benefits	**$83,726,125**			**$83,212,223**	-$513,902
5. Salary Savings					
a. CPCs 1.0%	**-$2,084,051**			**-$2,076,259**	$7,792
b. All Other Staff 5.5%	**-12,572,770**			**-12,468,103**	104,667
c. Total Salary Savings	**-$14,656,821**			**-$14,544,362**	$112,459
6. Early Start / Part C Administrative and Clinical Support (salaries, fringe benefits and salary savings)	$694,000			**$694,000**	$0
7. TOTAL PERSONAL SERVICES (Items A.3. + A.4. + A.5. + A.6.)	**$423,038,094**			**$420,468,289**	-$2,569,805
ROUNDED	**$423,038,000**	**10,122.00**		**$420,468,000**	-$2,570,000
B. OPERATING EXPENSES AND RENT					
1. Operating Expenses	**$39,785,000**			**$39,600,000**	-$185,000
2. Rent	**$52,022,000**			**$52,020,000**	-$2,000
a. Rent	*55,022,000*			*55,020,000*	
b. Elimination of Office Relocation and Modifications	*-3,000,000*			*-3,000,000*	
3. Subtotal Operating Expenses and Rent	**$91,807,000**			**$91,620,000**	-$187,000
C. TOTAL CORE STAFFING (Items A.7. + B.3.)	**$514,845,000**			**$512,088,000**	-$2,757,000

Attachment B

CORE STAFFING FORMULAS

CORE STAFFING CLASSIFICATION	STAFFING FORMULA		
A. PERSONAL SERVICES			
1. DIRECT SERVICES			
a. Clinical			
(1) Intake and Assessment			
(a) Physician (minimum of 1)	1.0 position	:	2,000 total consumers
(b) Psychologist	1.0 position	:	1,000 total consumers
(c) Nurse (minimum of 1)	1.0 position	:	2,000 total consumers
(d) Nutritionist (minimum of 1)	1.0 position	:	2,000 total consumers
(2) Clinical Support Teams			
(a) Physician/Psychiatrist	1.0 position	:	1,700 consumers in community care facilities (CCF) and supported living and those with severe behavior and/or medical problems
(b) Consulting Pharmacist	1.0 position	:	1,700 " "
(c) Behavioral Psychologist	1.0 position	:	1,700 " "
(d) Nurse	1.0 position	:	1,700 " "
(3) SB 1038 Health Reviews			
(a) Physician	1.5 hours	:	Referral/1,778 hrs./ full-time equivalent (FTE) position
(b) Nurse	1.75 hours	:	Individual program plan (IPP) review/1,778 hrs./FTE position
b. Intake/Case Management			
(1) Supervising Counselor: Intake	1.0 position	:	10 Intake Workers
(2) Intake Worker	1.0 position	:	14 monthly intake cases (assume average intake case lasts 2 mos.)
(3) Supervising Counselor: Case Management	1.0 position	:	10 CPCs in Items b.(4 and 5) below
(4) Client Program Coordinator (CPC)	1.0 position	:	62 Waiver and Early Start consumers (excluding CPP placements)
(5) CPC	1.0 position	:	66 consumers (all other consumers, excluding CPP placements)
(6) Supervising Counselor: Capitol People First	1.0 position	:	10 CPCs in Items b.(7) below
(7) CPC Capitol People First	1.0 position	:	66 consumers (Developmental Center residents)
(8) CPC, Quality Assurance for Alternative Residential Model	1.0 position	:	527 CCF consumers
(9) Supervising Counselor: DSS Incidental Medical Care Regulations	1.0 position	:	10 CPCs in item b.(10) below
(10) CPC, DSS Incidental Medical Care Regulations	1.0 position	:	2.5 hrs x 8 visits per year to CCF consumers who rely on others to perform activities of daily living

CORE STAFFING CLASSIFICATION	STAFFING FORMULA		
A. PERSONAL SERVICES (continued)			
1. DIRECT SERVICES (continued)			
c. Quality Assurance/Quarterly Monitoring			
(1) Supervising Counselor	1.0 position		10 CPCs in Item c.(2) below
(2) CPC	10 hrs/yr.	:	CCF consumer/1,778 hrs./FTE
	14 hrs./yr.	:	Supported/Independent Living consumer/1,778 hrs./FTE
	10 hrs/yr.	:	Skilled Nursing Facility and Intermediate Care Facility consumer/1,778 hrs./FTE
	10 hrs/yr.	:	Family Home Agency consumer/1,778 hrs./FTE
d. Early Intervention			
(1) General			
(a) Prevention Coordinator	1.0 position	:	RC
(b) High-Risk Infant Case Mgr.	1.0 position	:	RC
(c) Genetics Associate	1.0 position	:	RC
(2) Early Start/Part C			
(a) Supervising Counselor	1.0 position	:	10 CPCs in Item d.(2)(b) below
(b) CPC:			
Marginal positions from:	1.0 position	:	62 children<age 3yrs.
to:	1.0 position	:	45 children<age 3yrs.*
e. Community Services			
(1) Special Incident Coordinator	1.0 position	:	RC
(2) Vendor Fiscal Monitor	0.5 position	:	RC plus 1: every 3,140 vendors
(3) Program Evaluator	1.0 position	:	RC
(4) Resource Developer	1.0 position	:	RC
(5) Transportation Coordinator	1.0 position	:	RC
(6) Administrative Services Analyst (SB 1039, Chapter 414, Statutes of 1997) Consumer Complaints	0.5 position	:	RC
(7) Developmental Center Liaison	1.0 position	:	400 DC consumers
(8) Diversion	4.0 positions	:	21 RCs
(9) Placement Continuation			
(a) Supervising Counselor	1.0 position	:	10 CPCs in Item e.(9)(b) below
(b) CPC:			
1. Marginal positions from:	1.0 position	:	62 CPP Placements
2. to:	1.0 position	:	45 CPP Placements

* Note: This 1:45 staffing ratio is a funding methodology, not a required caseload ratio.

CORE STAFFING CLASSIFICATION	STAFFING FORMULA		
A. PERSONAL SERVICES (continued)			
1. DIRECT SERVICES (continued)			
f. Special Incident Reporting (SIR)			
(1) Supervising Counselor	1.0 position		10 CPCs in Item f. (2) below
(2) QA/CPC	1.0 position	:	RC plus 1:every 5,000 consumers
(3) Nurse	0.5 position	:	RC plus 0.5: every 5,000 consumers
g. Mediation			
(1) Clinical Staff	2.0 hours	:	25% of annual mediations/ 1,778 hrs /FTE position
(2) Supervising Counselor	4.5 hours	:	mediation/1,778 hrs./FTE position
(3) CPC	4.5 hours	:	50% of annual mediations/ 1,778 hrs./FTE position
h. Expansion of Autism Spectrum Disorders (ASD) Initiative			
(1) ASD Clinical Specialist (effective January 1, 2007)	1.0 position	:	RC
(2) ASD Program Coordinator (effective January 1, 2007)	1.0 position	:	RC
2. ADMINISTRATION			
a. Executive Staff			
(1) Director	1.0 position	:	RC
(2) Administrator	1.0 position	:	RC
(3) Chief Counselor	1.0 position	:	RC
b. Fiscal			
(1) Federal Program Coordinator (Enhancing FFP, Phase I)	1.0 position	:	RC
(2) Federal Compliance Specialist (Enhancing FFP, Phase II)	1.0 position	:	1,000 HCBS Waiver consumers
(3) Fiscal Manager	1.0 position	:	RC
(4) Program Technician II, FCPP	0.5 position	:	RC
	1.0 position	:	1,778 hours of FCPP determinations
(5) Revenue Clerk	1.0 position	:	400 consumers for whom RCs are representative payee
(6) Account Clerk (Enhancing FFP, Phase II)	1.0 position	:	RC
(7) Account Clerk	1.0 position	:	800 total consumers
c. Information Systems and Human Resources			
(1) Information Systems Manager	1.0 position	:	RC
(2) Information Systems Assistant	1.0 position	:	RC
(3) Information Systems Assistant, SIR	0.5 position	:	RC
(4) Privacy Officer, HIPAA	1.0 position	:	RC
(5) Personal Computer Systems Manager	1.0 position	:	RC
(6) Training Officer	1.0 position	:	RC
(7) Training Officer, SIR	0.5 position	:	RC
(8) Human Resources Manager	1.0 position	:	RC

CORE STAFFING CLASSIFICATION		STAFFING FORMULA
A. PERSONAL SERVICES (continued)		
2. ADMINISTRATION (continued)		
d. Clerical Support		
(1) Office Supervisor	1.0 position :	RC
(2) PBX/Mail/File Clerk	3.0 positions :	RC
(3) Executive Secretary	2.5 positions :	RC
(4) MD/Psychologist Secretary II	1.0 position :	2 Physicians in Item 1.a.(3)(a), SB 1038 Health Reviews
(5) MD/Psychologist Secretary I	1.0 position :	2 Physicians/Psychologists in Items 1.a.(1)(a) and (b), Clinical Intake and Assessment
(6) Secretary II	1.0 position :	6 professionals in Items: 1.a.(3)(b), SB 1038 Health Reviews 1.b.(9) and (10), DDS Incidental Medical Care Regulations 1.c., Quality Assurance/ Quarterly Monitoring 1.e.(1), (2) and (9)(a) and (b) Community Services 1.e.(9)2., Community Services (see Secty I, line 1.e.(9)1., below) 1.f.(1) thru (3), Special Incident Reporting 2.b.(1), Federal Program Coordinators (FFP Phase I) 2.b.(2), Federal Compliance Coordinators (FFP Phase II) 2.c., Information Systems and Human Resources
(7) Secretary I	1.0 position :	6 professionals in Items: 1.a.(1)(c) and (d), Clinical Intake and Assessment 1.b.(1) to (5) and (8), Intake/Case Mgt. 1.b.(6) and(7) Capitol People First 1.d., Early Intervention 1.e.(3), (4), (6) to (8), Community Services 1.e.(9)1., Community Services (see Secty II, line 1.e.(9)2., above)

ATTACHMENT B

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE ADDED SERVICES

PUBLISHED BY

FRANK D. LANTERMAN REGIONAL CENTER

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE-ADDED SERVICES

Over the years, as the state legislature has sought acceptable strategies to resolve repeated budget shortfalls, stakeholders in the developmental service system have offered a variety of remedies to reduce costs. Proposed solutions have included changing or reducing the entitlement defined by the Lanterman Act, implementing parental cost-sharing or co-payment requirements, cutting reimbursement to service providers, and reducing funding to regional centers and developmental centers.

One proposal to achieve savings in regional centers has been to cut regional center "operations". Those who recommend this as a solution argue that this would do no more than reduce "red tape," and that taking money away from what some perceive to be strictly administrative functions would leave more money for purchasing services for clients.

This argument fails to recognize that the vast majority of activities classified as operations in the regional center budget are actually direct services to clients and their families. As stated in the Lanterman Act, it was the intent of the Legislature that "the design and activities of regional centers reflect a strong commitment to the delivery of direct service coordination and that all other operational expenditures of regional centers are necessary to support and enhance the delivery of direct service coordination and services and supports identified in individual program plans (Section 4620)."

Most "operations" activities are direct services to clients and families.

In conceptualizing the model for the regional center system, the legislature found that "the service provided to individuals and their families by regional centers is of such a special and unique nature that it cannot be satisfactorily provided by state agencies." They reasoned that the array of services and supports required by people with developmental disabilities and their families was so complex that the necessary coordination could not be successfully managed by any existing agency. For this reason, the legislature made the decision to contract with private non-profit community-based agencies to be the organizing hub and center for coordinating services. The mission of these organizations – called regional centers – was two-fold: to ensure that people with developmental disabilities would be afforded the opportunity to live independent, productive and normal lives alongside their non-disabled peers in the community; and to minimize the risk of developmental disabilities and ameliorate developmental delays in infants and young children who are at risk.

In this paper, we attempt to show why the term "operations" when applied to the vast majority of activities of the regional center is a misnomer. We clarify what is included in this category and how many of these activities are more accurately described as direct services to clients and families. While regional centers do have an administrative role, it is small in comparison to the range of direct services provided by regional center staff to clients and families.

We begin by looking at the overall regional center budget and how funding is allocated within centers between purchase of service and operations. While most of this information is derived from Lanterman Regional Center, the general findings can be applied to the other regional centers in California.

How Regional Center Funds are Allocated

The regional center receives funding for two purposes:

- purchasing services for clients and families from community service providers (POS); and
- operating the center, including, for example, paying staff salaries and office rent and purchasing supplies and telephone service (Operations).

Figure 1, below, provides a graphical representation of the relative amounts of the regional center budget that are apportioned to POS and Operations. As can be seen from this chart, POS accounts for approximately 87% of the total regional center budget. The remaining 13% is allocated between what is often called *general administration* (2%) and activities that are *direct services* (11%) to clients and families.

Figure 1

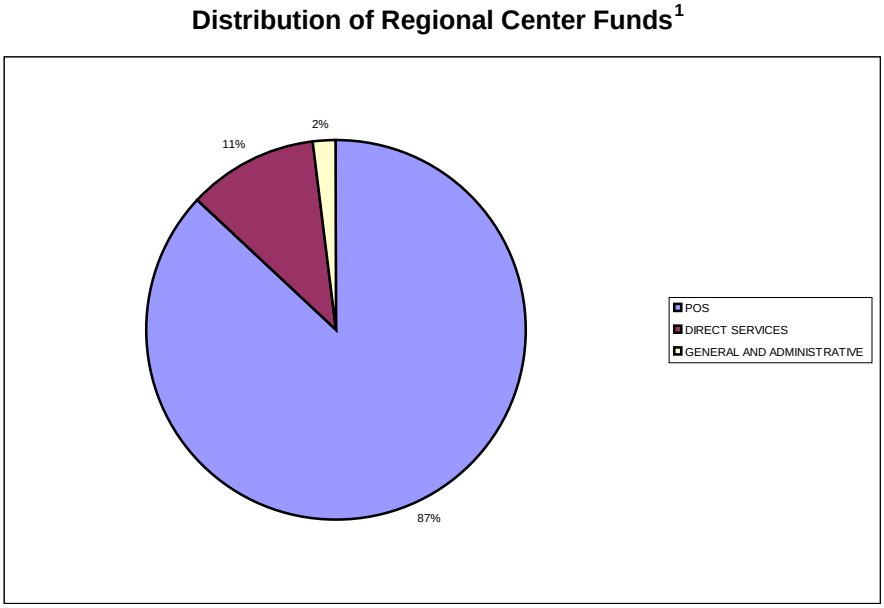
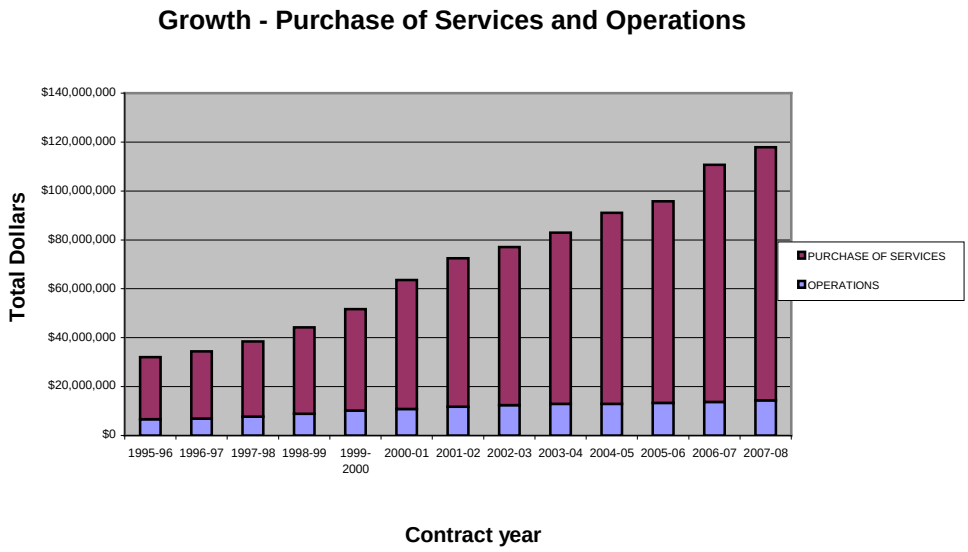


Figure 2, below, illustrates the comparative increases in purchase of service and total operations expenditures between 1995-96 and 2007-08.

[1] Figures are taken from Lanterman Regional Center independent audit report for 2007.

Figure 2



The figure shows that, during that 12-year period, POS expenditures grew at almost twice the growth rate for operations. In 1995-96, "operations" equaled 21% of the regional center budget, whereas currently this category accounts for slightly less than 13% of spending.

Regional centers have not received cost-of-living adjustments since 1991-92.

What is not shown in *Figure 2* is the significant disparity between regional center staff salaries as reflected in the "core staffing formula" used by DDS to fund centers and the actual salaries of regional center staff as demanded by the marketplace. The core staffing formula originally keyed regional center salaries to the mid-range salary of the equivalent state positions at the time each regional center position was added to the formula. Until 1991-92, regional center positions received annual cost-of-living adjustments equivalent to the adjustment received by state employees but the state ceased making these adjustments in 1991-92. From that year until the present, with one exception, the state has not authorized cost-of-living adjustments for regional center staff. The exception occurred in 1998-99 when the state authorized a one-time increase in the core staffing salary for service coordinators. This was in response to controversy surrounding a report[2] concluding that the risk of death increased for people moving from the developmental center into the community.

To highlight the disparities resulting from the failure to adjust regional center salaries, *Table 1* below compares salaries as reflected in the core staffing formula with actual salaries for two regional center positions.

[2] Strauss, D. J. and Kastner, T. A. (1996). Comparative mortality of people with mental retardation in institutions and the community. *American Journal of Mental Retardation* **101**, 26-40.

Table 1

Position	Core Staffing Salary	Regional Center[3] Average Salary
Service Coordinator	$34,032	$42,500
Accounting Associate	$18,397	$36,162

Currently, the actual salaries for LRC staff exceed the total in the core staffing formula by slightly more than 20%. Regional centers adjust for these disparities by employing fewer people than are allocated in the core staffing formula.

OPERATIONS: WHAT DOES IT INCLUDE?

In this section, we take a closer look at what is included in the operations category. We begin by looking at the direct services provided by regional center staff.

Service Coordination for Clients over Age 3

Service coordination consists of a unique set of responsibilities assigned to regional centers by the Lanterman Act. It is the cornerstone service provided by the regional center. This service is universally received by every client and is central to ensuring that the service system meets every client's needs.

Lanterman Regional Center employs approximately 110 professionals who help plan and coordinate services for 7,400 children and adults living at home, in the community, and in the developmental center. These service coordination activities occur in face-to-face meetings as well as via mail, telephone, and e-mail communications. Service coordinators (SCs) work with clients and families on the development of person-centered plans, called Individual Program Plans, or IPPs, and they conduct annual reviews of these plans.

For clients living in licensed residential homes and supported living, SCs also conduct quarterly face-to-face reviews at the home. LRC has approximately 1,000 clients living in these two settings and, for many of them who have no family or others to advocate for them, the SC plays a major role in ensuring that they receive the services, supports, and other opportunities that they need to be active members of their community. In 2007, SCs conducted more than 1,800 IPPs and 3,700 annual reviews, and nearly 4,000 additional quarterly face-to-face visits to clients' homes.

Service coordinators provide IPP development and periodic review, authorization of services, review of client progress, residential monitoring, assistance with IEPs and ITPs, linkage with generic services, advocacy, and crisis intervention.

[3] The regional center data reflects findings of a July, 2007 Hewitt Associates survey of compensation at 9 Southern California regional centers.

As part of each annual review, the SC also completes a health status review, intended to ensure that the client is receiving the recommended medical, mental health, and dental care, and an annual assessment of client adaptive behavior (the Client Development and Evaluation Record, or CDER). SCs whose clients live in a licensed home also participate with staff of the center's Community Services Department in monitoring the quality of services provided in those settings.

Prior to receiving most types of purchased services, a client is formally assessed to determine the necessity and appropriateness of the proposed service. SCs receive and review these reports and, if services are determined to be necessary, identify programs or professionals to provide the services and issue authorizations to purchase services. In many cases the search for a provider requires multiple phone calls to find a provider who is both appropriate and has the capacity to take on a new client. This is a particular problem with regard to speech therapy. Service coordinators typically contact three or four providers before identifying one who will accept a client. In some cases, service coordinators have been required to contact up to ten therapists.

For those clients who receive services, providers are required to submit periodic reports reflecting their progress toward achieving the goals identified in the service plan. Service coordinators have a quality control responsibility - reviewing such reports for all of their clients to ensure that appropriate services are accessed and that the client is making progress toward the stated goals. All reviews and authorizations – for new services, for continuations, and in situations where families or clients request changes in vendors, dates of service, etc. – must be completed in a timely manner so that there is no delay or interruption in services. An SC typically completes between 100 and 200 individual authorizations in a month.

SCs are responsible for receiving and reviewing medical records and, for children in school, Individual Educational Programs (IEPs) and Individual Transition Plans (ITPs). They also help parents prepare for IEP meetings and, at parents' request, attend the IEP and ITP meetings to help the parents advocate for needed services.

Family Cost Participation Program. Service coordinators play a role in implementing the Family Cost Participation Program, begun in 2005 and applying to families of children ages 3 to 17, inclusive, who are not covered by Medi-Cal. This program requires parents to share in the cost of certain services purchased by the regional center for their children. SCs review circumstances of families that meet the criteria for participation in this means-tested program, explain the program to the parents, obtain the required financial information for eligible families, and submit it to the center's fiscal monitor. During 2007, 257 additional families were evaluated for participation and 101 were assessed a share of cost. The number of families evaluated is expected to increase since, in 2008, the program was expanded to included children age birth to 3 receiving early intervention services.

Service Coordination for Children under Age 3 (Early Start)

Early Start is California's name for its early intervention program for children age 0 – 3. Lanterman Regional Center currently serves 1,330 children in this program. For these children, SCs coordinate development of an Individualized Family Service Plan (IFSP) every year and

review that plan every six months. In 2007, SCs completed 1,225 IFSPs and 407 six-month reviews.

Early Start SCs provide outreach and case finding through activities such as maintaining liaison relationships with six neonatal intensive care units serving the Lanterman area. They also have been very successful in helping toddlers gain entry to typical (integrated) preschools. In 2007, 480 children (more than 90% of the center's preschool age clients) were enrolled in community-based preschools.

In 2007, Early Start service coordinators helped more than 90% of the center's preschool age clients enroll in typical preschools in the community.

Children receiving early intervention services are evaluated a second time, when they reach 2 ½ years of age, to determine whether they will be eligible for continued regional center services after age 3. As a result of the services provided through the Early Start program, approximately two-thirds (68%) of these children have caught up with their typical peers and they "graduate out" of the program. These children are no longer eligible for regional center services, although some of them – for example, children with specific learning disabilities – may receive specialized services through the school district. For these children as well as for children who will remain regional center clients, Early Start service coordinators work with families to ease their transition into the public school program.

Coordination of Services

SCs are the *primary contact linking clients and families with services and supports* needed to implement IPPs and IFSPs. They must ensure cooperation and collaboration across agencies and service providers in the interest of clients. This linkage may be to public and community agencies serving the general public, such as the schools, the Department of Rehabilitation, and Social Security, or it may be to regional center authorized service providers. SCs monitor the service relationships to ensure that they are effective in helping clients achieve their desired outcomes, and they intervene when problems or questions arise. These responsibilities require SCs to maintain intensive communications, both verbal and written, with community agencies, direct service providers, and clients and families.

Social work responsibilities. In addition to their service coordination responsibilities, SCs do a significant amount of case management in the social work tradition. (Early in the history of regional centers, SCs were social workers.) For example, they routinely deal with a range of crises experienced by their clients and families, including parents attempting to come to terms with a new diagnosis. They also cope with issues related to domestic violence, divorce, eviction and homelessness, food insecurity, and death or illness of a primary caregiver. Particularly with younger adult clients, they may be called upon to become involved with law enforcement or the courts when a client is thought to have committed a crime.

Information. The SC is the primary keeper of information about the client, the services he or she receives, and significant events in his or her life. This responsibility involves a significant amount of clerical work that arguably would be more appropriately handled by clerical or

secretarial staff if they were available. In the early 1990s, budget pressures caused regional centers to reduce operations costs by eliminating selected support staff. As a result, for example, service coordination units at Lanterman Regional Center were left with one secretary to support 10-12 service coordinators and a regional manager. As a consequence, SCs responsibilities include word processing, handling their own mail, copying, and filing.

Community Placement Plan.

As the primary mechanism for implementing the state's commitment to moving people out of state developmental centers (DCs), Community Placement Plans are created by all regional centers and submitted to DDS for approval. These plans include the identification of DC residents whose needs, as judged by their ID teams, can be met in a community residential setting. For each of these individuals, the ID team assesses their support needs and preferences, and, in partnership with the regional center's Community Services Department, identifies or develops residential and other resources to support these clients in the community.

Lanterman's Community Living Options (CLO) team of four Community Living Specialists (CLS) currently provides specialized service coordination to 62 clients who have moved to the community from a developmental center under the Community Placement Plan. At this time, 101 individuals continue to reside in the DC and the appropriateness of community placement for these residents is discussed at every IPP meeting. An enhanced caseload ratio required for the CLO team (1:45) allows for monthly visits for the first six months after community placement, quarterly progress reviews, annual IPP development and semi-annual review, court reports, and special resource development and re-direction efforts to assist and maintain community placement. CLO staff are also responsible for "deflecting" clients in the Lanterman community who are at risk of being committed to a DC.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move. Since some DC residents are in that placement as the result of a judicial order, the transition process includes a series of court hearings and formal reports to keep the court informed about the status of the transition.

Federal and state laws, reinforced by judicial decisions, support the right of people with disabilities to live in the least restrictive setting. Parents or other family members, however, may be comfortable with the services their relative is receiving in the DC and reluctant to engage in what they view as "change for change sake." Staff of developmental centers are also sometimes resistant to residents leaving their protective environment. A major role for CLO service coordinators, therefore, is to develop a trusting relationship with the family that can serve as the basis for a mutual partnership focused on obtaining an appropriate home for the client in the community. Once such a relationship is developed, SCs work with the family and DC staff in identifying an appropriate community resource, orienting them to what will be necessary to support the client in this less

restrictive living arrangement, and working closely with them in an ongoing way as the transition progresses.

Coordination of appeals. The responsibility for appeals coordination, including both informal appeals at the regional center level and formal hearings with the Office of Administrative Hearings, rests with the division of Client and Family Services. In 2007, a total of 30 requests for fair hearing were filed in the following categories:

- Eligibility – 14 (47%)
- Intensive services for autism – 5 (17%)
- Legal services – 3 (10%)
- Other services – 8 (27%)

Emergency response. Regional center staff respond to urgent situations and emergencies after hours and on weekends. Clients, families, and service providers can contact an on-call staff person 24 hours a day, 7 days a week through the center's emergency line. The most frequently encountered emergency situations include clients who go missing, instances of potential abuse, emergency hospitalizations requiring consent from the regional center, and emergency placements (e.g., for clients whose family has an urgent need for respite). Calls from police departments are also common. When a person with no identification and an inability to communicate is brought to the attention of police, they frequently call the regional center seeking help in identifying the individual. The person may not be a client of the regional center called or may not even be a regional center client, but rather a person with a serious mental illness. In any case, the regional center is expected to provide assistance to the police in their attempt to identify the individual.

Managing risk. Service coordinators, in collaboration with staff of the center's departments of Community Services and Clinical Services, have the primary responsibility for investigating Special Incidents. Special Incidents are occurrences that potentially threaten the health or welfare of clients. Because of their potential serious consequences for the client, they must be handled expeditiously. The service coordinator and other involved staff members must immediately turn their full attention to the investigation of the incident. A service coordinator whose caseload consists of clients living in licensed homes typically has 1 – 2 special incidents to investigate per week, each of which requires a minimum of 3 to 4 hours. The most time consuming type of Special Incident investigation, potential abuse, requires an average of 8-10 hours to complete.

Special incidents include events such as unexpected hospitalizations, physical injury, lost or missing clients, and suspected abuse. The aim of a Special Incident investigation is to intervene quickly to resolve a problem, to determine whether the occurrence was preventable and, if it was, to develop strategies or interventions to prevent a recurrence.

In 2007, Lanterman staff members investigated and resolved 1903 Special Incidents. Many of these investigations required the service coordinator to intervene on behalf of the client with a community agency such as a hospital, the Department of Children and Family Services, the Department of Mental Health, a law enforcement agency or court, Adult Protective Services, or the county's Public Guardian Office. The center's Risk Management Committee monitors

Special Incidents at the aggregate level to determine if there are any systemic issues warranting action by the regional center – for example, implementation of training initiatives, changes to policies or procedures, or the development of new services and supports.

Targeted Case Management (TCM) Program. As a condition of the state obtaining federal financial participation in the funding of regional centers, service coordinators are required to document all of their direct service activities in the interdisciplinary (ID) notes section of their clients' records. The federal government has imposed strict requirements on this documentation – for example, services must be described precisely and in a specific format, and time must be recorded in 15-minute increments. This information is submitted by the regional center to the Department of Developmental Services on a monthly basis. DDS, in turn, bills the federal government for these services. The TCM program brings approximately $140 million in federal funding into the state each year.

Advocacy

The Lanterman Act assigned to regional center service coordinators the role of front line advocate, assisting clients and families in exercising their civil, legal, and service rights. In 1997 funding for advocacy was removed from regional center budgets and transferred to the Office of Client Rights Advocacy, but the primary responsibility for advocacy remains with regional centers and is an important function of service coordinators. SCs represent clients' interests with service providers in the community as well as with generic services such as the school system and the Department of Rehabilitation. In 2007, service coordinators attended Individual Education Program (IEP) meetings for more than 460 clients, and they helped more than 937 families gain inclusion for their sons and daughters in regular classrooms with their typical peers.

Service coordinators helped 937 families gain inclusion for their sons and daughters in regular classrooms with typical peers.

SCs also serve a critical advocacy function helping clients and families achieve and maintain eligibility for entitlements such as Medi-Cal and SSI, and they assist families dealing with criminal justice and immigration matters. For a majority of clients who become involved with the criminal justice system, regional center service coordinators are asked by the court to write a diversion plan to be implemented in lieu of incarceration. In this activity, they work with the public defender or probation department to create a plan of education, restitution, or correction with a goal of preventing the client's future involvement with the justice system. In these cases, service coordinators are required to monitor the client's progress on the plan and submit periodic reports to the court on the client's status.

Through the Koch-Young Resource Center, described below, the center offers an 8-hour course for Lanterman families to help them become more effective advocates for their family member with a disability. This course, called Service Coordinator and Advocacy Training (**SCAT**), is conducted four times a year, three times in English and once in Spanish. The center also offers more specialized educational and training opportunities to help families further sharpen their advocacy skills and learn about services and benefits available for their sons and daughters. These classes focus on transition into school, the individual educational program (IEP) process, transition from school to work, and SSI and employment benefits.

Clients are able to develop and practice their own self-advocacy skills though involvement with the regional center's governance board and committees and the Client Advisory Committee . They are also currently attempting to organize a local chapter of People First.

Three formal self-advocacy experiences, are available to adult clients through the center's Training and Development Department. These programs, which are the responsibility of the center's Peer Advocate, include:

- Women's Reproductive Health Self-Advocacy Training: A peer-advocacy-based training program for women with developmental disabilities; topics include basic anatomy, menstruation, menopause, pregnancy, sexually transmitted diseases, contraception, the importance of women's health exams, and using self-advocacy to communicate with your doctor.
- Abilities: A sexual abuse and exploitation risk-reduction program for adults with developmental disabilities, including topics such as what is sexual abuse, assertiveness training, self-esteem and communication, personal safety training, and what to do if a person is ever sexually abused or assaulted.
- Project Prepare: Disaster preparedness training for clients.

Resource Center staff also recruit students, arrange sites for, and coordinate delivery of two additional programs which are offered by outside organizations. These programs are:

- Get Safe: A personal safety program for adults, teens, and children, including topics such as assertiveness training, community safety awareness, setting limits, defining boundaries and creating healthy relationships.
- SHASTA: A sexual health and safety program for teens and adults.

Intake and Assessment

Intake staff members oversee the process through which prospective clients are assessed to determine whether they are eligible for regional center services – i.e., are at risk for a developmental disability or have such a diagnosis and are substantially handicapped. The Intake Unit completed 1,617 intake and assessments during 2007, completing the process within legally mandated time frames. Approximately 70% of these intakes were for infants and toddlers under age 3.

Regional center are allowed 45 days from the time of the first phone call from a family to complete the development of an Individual Family Serivce Plan for children under age 3.

Intake timelines for the Early Start program are particularly stringent. While 120 days is allowed for completing intake and assessment for applicants over age 3, for children under 3 regional centers are allowed only 45 days from the time of an initial phone call from a family to complete the development of the Individualized Family Service Plan (IFSP). During this time period regional center staff must meet with the family; ensure that formal assessments are completed; review assessment reports and consult with clinical staff to determine eligibility; decide, in cooperation with the family, what services and supports will be provided; complete the writing of the IFSP; and initiate the purchase of services.

For prospective clients who are determined not eligible for regional center services, intake and assessment staff serve as a source of information and referral to other public and private resources that might meet their needs and the needs of their families. These staff members also engage in outreach activities with agencies such as the Department of Children and Family Services, the Department of Mental Health, homeless shelters, and the Los Angeles City jail, to enhance case finding and ensure that referrals made by these agencies are appropriate.

Clinical Services

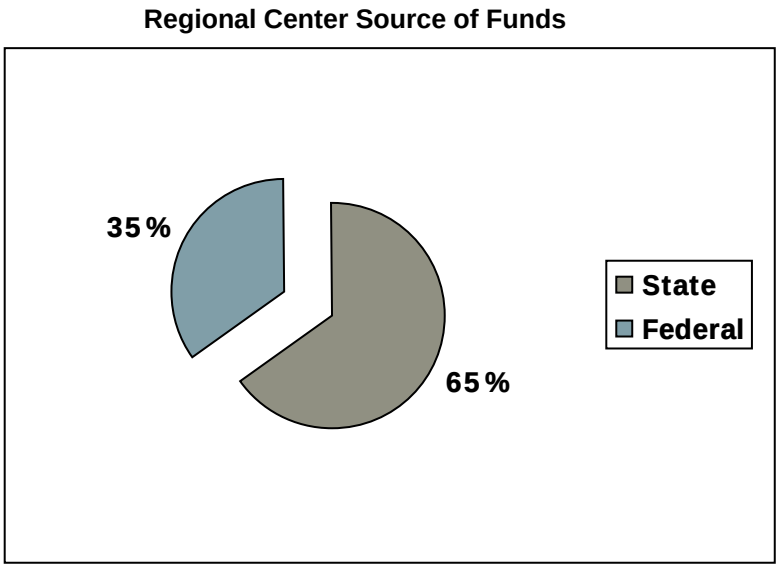
Using an interdisciplinary team approach, Clinical Services specialists conduct a variety of activities aimed at ensuring and improving the health and well-being of clients. Nurses, physicians, psychologists, a dental hygienist, and a dentist are involved in:

- individual clinical assessments of clients;
- review of services being provided to clients by community professionals, and direct consultation with these professionals;
- consultations with service coordination staff on specific clients' health issues;
- consultation with and technical assistance to service providers;
- participation in annual review meetings for clients who have significant health related issues or concerns;
- review of requests for the use of psychoactive medications with clients;
- consultation with service coordination staff on Medicare Part D issues;
- oversight of the review process required under the federal Nursing Home Reform program;
- review of requests for surgical and other interventions from medical professionals, consultation with those professionals about the requests, and providing consent, as appropriate, when no other party is authorized to assume this responsibility;
- mortality review in all cases of client death.

The center's Bio-ethics Committee reviews requests from physicians or families to impose a "Do Not Resuscitate Order" or order hospice or palliative care for a client. The committee develops a report with recommendations for the Executive Director who makes the final decision and forwards it to the institution's Bio-ethics Committee.

Medicaid Waiver. A major activity of Clinical Services is certification and annual re-certification of clients for eligibility under the Home and Community Based Waiver (HCBW) program. This is a collaborative effort of Clinical Services staff and service coordinators, and is part of a program that brings a very substantial amount of federal funding into the developmental services system. Approximately 1,900 of Lanterman's 7,400 clients are currently certified for the waiver. This number represents a 20% increase from the 2006 waiver enrollment. Statewide, the HCBW program brings more than $750 million into the Developmental Services system. *Figure 3* on the following page gives a graphical representation of the portion of the regional center system budget that is covered by federal financial participation, including Medicaid Waiver and Targeted Case Management. As can be seen, these federal funds constitute slightly more than one-third of the total budget for regional centers.

Figure 3



The Clinical Services Department also develops and manages special projects targeted at objectives such as improved dental health, prevention of unnecessary hospitalization, ensuring appropriate use of medications in group homes, enhanced access to psychiatric services, and improved support for aging clients to enable them to "age in place" in the community. For these projects, the regional center has partnered with organizations such as USC Schools of Medicine and Dentistry; UCLA Schools of Medicine, Dentistry, and Nursing; University of the Pacific Special Needs Dentistry; the Semel Institute at UCLA, Childrens Hospital Los Angeles, and LA Care and Health Net Health Plans.

Family Support

The Koch-Young Resource Center (KYRC) is dedicated to the provision of information and support to clients and families and to the professionals who support them. The Center maintains a Help Desk and associated telephone Help Line that responded to approximately 3,000 information and referral requests in 2007. It contains a multimedia lending library housing thousands of educational materials available to clients, families, service providers, and members of the larger community. Nearly 1,200 individuals are registered users of the library.

Nearly 1,200 individuals are registered users of the Koch-Young Resource Center Library.

During 2007, KYRC staff distributed over 1,000 Welcome Kits to new regional center families. These kits contain materials of general interest to new families as well as information that is specific to their children's disabilities. They also publish the ***Viewpoint*** newsletter and support the Lanterman web site, both critical tools for communicating with the Lanterman community. In 2007, the web site had approximately 30,000 unique visitors who viewed more than 70,000 unique pages. During the summer of 2007, the center launched the Network of Care through the center's website. This is a searchable database of more than 975 community resources that

integrate children and adults with developmental disabilities into regular programming and activities with their non-disabled peers. The network listing is continually updated and expanded.

The Resource Center currently coordinates 19 family support groups providing mutual support, education, information sharing, and advocacy. A service coordinator is involved in each of these groups in partnership with and as a mentor for the parent who acts as co-facilitator. The Resource Center also coordinates 3 client support groups and two intensive Sibling Support Groups for children and adolescents whose siblings are regional center clients. It also maintains the Peer Support Program where approximately 40 experienced parents are actively involved in offering one-to-one emotional support and information to families who are new to the center or families who request a partner for a specific purpose.

The KYRC coordinates the regional center's volunteer program. In 2007, approximately 20 volunteers, most of whom are clients, completed over 1,200 hours of volunteer effort on tasks such as mass mailings. Through the KYRC, the regional center has also developed internship opportunities intended to bring young people with non-traditional backgrounds, such as business and the sciences, into the regional center to apply their knowledge and skills while learning about developmental services. The capstone of that effort is the Roberta Happe Memorial Internship, established in 2001.

The Resource Center has been instrumental in developing and maintaining partnerships with community-based organizations with a goal of expanding educational, skill-building, and other opportunities for people with disabilities. In partnership with the Los Angeles Unified School District, Lanterman hosts two computer training classes each semester for clients, family members, and caregivers. As of the end of 2007, 120 students had graduated from these classes with beginner and intermediate computer skills. Up to 60 students are served in each class series and each series is offered four times per year.

The KYRC also maintains partnerships that offer more inclusive opportunities for people with disabilities in programs serving the general public. Such partnerships have been created with Community Technology Centers, offering clients who complete computer classes at LRC an opportunity to transition to advanced training in the community, and local public libraries to provide clients with a variety of opportunities generally available to the wider community.

Assistive Technology Project. Another valued component of the KYRC is the Assistive Technology Project (ATP) that provides consultations, information, and advice to clients and families of clients who might benefit from the use of technology to learn, communicate, or complete activities of daily living. This project is the result of a partnership between Lanterman Regional Center and the Assistive Technology Exchange Center (ATEC), a division of Goodwill of Orange County. The project has provided more than 40 AT "labs" where parents can explore assistive technology options, more than 500 consultations and 200 individualized assessment of need, and 4 AT workshops for service providers. The regional center also partnered with the USC Occupational Therapy program to offer an OT internship focused on assistive technology.

Quality Assurance and Improvement Activities

Residential services. The Community Services Department is responsible for a range of activities mandated by Title 17 and aimed at ensuring the health, safety, and well being of clients living in licensed homes and improving the quality of services provided there. Regular monitoring visits to group homes and other residential settings are also intended to ensure that the residents' rights are protected, that residents' personal funds are being appropriately managed, and that residential staff are helping residents maximize opportunities to participate in the life of the local community. Regional center staff also provide technical assistance and training to service providers to increase their skills and enhance the quality of services they provide. Four Community Services staff members currently monitor 120 homes, 13 of which are Community Placement Plan (CPP) homes.

The monitoring function requires regional center staff to conduct two unannounced visits to each licensed home each year. The regional center is also required to conduct an announced in-depth, day long, comprehensive team evaluation of each home every three years. Given the broad scope of the team evaluation, the Service Coordinator who acts as liaison to the home participates as a member of the team. The Quality Assurance staff conduct the mandated exit interview with the residential provider and write the evaluation report within the mandated timelines.

CPP homes are specialized homes for people moving out of the state developmental center. Given the complex and often intense needs of these clients, the Quality Assurance staff conduct quarterly monitoring of CPP homes to ensure that the client's needs are being met and their health and safety are being ensured.

Homes that do not meet regulatory standards are required to implement Corrective Action Plans. Quality Assurance staff provide technical assistance in development of these plans and they conduct additional unannounced visits to ensure that they are implemented appropriately. They also conduct two subsequent unannounced visits to ensure that the home continues to meet expectations of the CAP.

For all newly vendored residential providers, Quality Assurance staff conduct an orientation and two technical assistance visits in addition to the other required visits. The orientation and technical assistance visits aim to ensure that new providers understand and satisfy regulatory requirements and regional center expectations.

Work-related services. The four Community Services staff members who monitor licensed homes have additional mandated responsibilities with regard to work programs. These activities are aimed at ensuring that work programs are providing paid work opportunities to clients in a safe environment, and that work programs are in substantial compliance with national accreditation standards. Community Services staff provide technical assistance and training to these providers as needed or requested. Lanterman staff currently monitor 10 work programs. These responsibilities were transferred to the regional center from the Department of Rehabilitation in 2004, but no funding accompanied the transfer.

Other services. Community Services Quality Assurance staff members annually monitor day programs, independent living services (ILS), and supported living services (SLS) programs to ensure that they meet regulatory requirements and regional center expectations. These staff members provide technical assistance and training to these providers as needed or requested. They currently monitor 23 day programs, 10 ILS programs and 13 SLS programs. The center's budget does not include staffing to perform monitoring for these three types of services.

Complaint investigations. Community services staff investigate all complaints against vendored service providers. Depending on the nature of the complaint and the number of people who must be interviewed, a complaint investigation requires between one and five days. Community Services staff provide technical assistance and training to these providers as needed. A meeting is held with the provider to discuss the complaint and the findings of the investigation team. Following the meeting, a letter is sent to the provider summarizing the complaint, the results of the investigation, and any further actions needed. Community Services staff participated in 91 of these investigations in 2007.

Resource Development

The Community Services Department is responsible for ensuring that the service system includes the types and numbers of services necessary to meet the service needs of the more than 7,400 children and adults with developmental disabilities in the Lanterman service area. This responsibility includes the entire range of services – e.g., living options, day programs, work programs, autism services, and therapeutic services.

Resource Specialists provide technical assistance to all potential service providers, reviewing regulatory requirements and regional center procedures and expectations, and reviewing the vendor application packet to ensure that those who request vendorization are qualified to meet the needs of people they intend to serve. Site visits are conducted for all potential center-based services and transportation companies to ensure that a safe environment exists. Licenses and credentials, where applicable, are verified. Therapists who seek to conduct in-home services are required to submit three professional references, and these are verified. While not mandated by Title 17, these precautions are taken to ensure the health, safety and well being of all regional center clients who will potentially receive services from the provider.

Because the Centers for Medicare and Medicaid Services promote choice, residential and community based non-residential programs are required to prepare a program design that describes the services to be provided, curriculum, staff qualifications and training, and more. Community Services staff read each program design and provide written feedback to the potential provider. The average program design is 50 pages in length and is typically revised several times before it meets Title 17 standards and satisfies regional center expectations.

The Resource Developer also ensures that appropriate services are developed for clients moving into the community from developmental centers via the Community Placement Plan. These resources are specialized and require community services staff to do increased monitoring, technical assistance and training to ensure the client's needs are met.

Vendorization

The regional center's vendor list includes thousands of providers in the Lanterman area, each of which has a record that must be maintained and updated when changes are made to the provider's name, address, telephone number or rate, or when the provider begins providing a new service. This information must also be made available to other regional centers that use the service provider.

Families wishing to purchase their own diapers, respite, pre-school programs, or transportation are also required to be vendored and must work with community services staff to complete an application and obtain a vendor number. Clients and families seeking to be reimbursed for purchases they made for authorized services or products also must be vendored. The regional center newly vendored 128 providers and made changes to 386 vendor files in 2007.

The regional center requires that providers maintain appropriate insurance coverage as a condition of doing business with the center. A separate database is maintained by the regional center to ensure that providers purchase insurance and renew it annually. Reminder notices are sent to providers who fail to provide proof of annual renewal of coverage.

Client Benefits Coordination

Three staff members in the center's Administrative Services Department spend 100% of their time coordinating client benefits. They are responsible for managing the SSI funds and other public benefits for approximately 1125 clients for whom the regional center is the representative payee. These are clients who are unable to manage their own finances and have no family or other appropriate representatives able or willing to help them with this responsibility. These three staff members currently manage more than $9 million in clients' funds. They also manage the processing of applications for Supplemental Security income, Medi-Cal, and other programs for these 1125 clients as well the annual re-determination of eligibility for these programs. Finally, these employees process an additional 2,000 forms that are required by Social Security Administration for a variety of purposes.

Fiscal Monitoring

One staff member coordinates the development of and monitors more than 84 contracts related to the center's operations and purchase of service activities. Nearly 90% of these contracts pertain to direct services provided to clients. This task is essential to ensuring careful stewardship of funds entrusted to the regional center. The fiscal monitor completed 45 vendor audits in 2007, 11 of which were required, and coordinated recovery of overpayments. She also shares responsibility with service coordination staff for implementation of the Family Cost Participation Program. She receives income information on eligible families and assesses an appropriate share of cost for families who are determined to be participants. In the three years since the inception of this program, 459 families have been reviewed and 252 have been assessed a share of cost for services, as prescribed by law. With the expansion of this program to Early Start clients, the number of families involved in this program each year is expected to increase.

Training

The regional center creates, conducts, and coordinates a wide range of educational and skill development activities for clients, families, service providers, and regional center staff. A director and 1¼ members staff develop, coordinate, and conduct training programs tailored to the needs of clients, parents, services providers, and regional center staff. In 2007, they oversaw the delivery of or conducted 112 programs, including sexuality and socialization skills, personal safety, disaster preparedness, transition to work training, and leadership development. The center also supported the participation of 359 clients, parents, staff members, and providers in 111 local, state, and national conferences.

GOVERNANCE AND ADMINISTRATION

In terms of the entire budget, governance and administration costs – everything other than purchase of services and regional center direct services to clients and families – account for slightly more than 2% of total expenditures. We now take a closer look at what is included in that portion of the budget.

Board and executive activities. The regional center is a community-based, non-profit organization governed by a volunteer board of directors that includes parents, clients, and other interested citizens. The Board along with its executive staff has primary accountability to ensure that the center meets the requirements of all applicable federal and state laws and regulations, including those required for federal financial participation, and of its contract and performance plan with the state Department of Developmental Services, The Board has also committed the center to four strategic initiatives that are critical for our clients and their families: inclusion, information and technology, affordable housing, and employment.

The executive director and senior staff work together to create a climate of accountability and an environment that promotes quality, innovation, and cost-effectiveness within both the center and the center's network of community service providers. The Board and executive group also provide vision and leadership for the creation of special projects intended to enhance the service system and the quality of services provided. A particularly successful example of such projects is the UCLA/NPI/Lanterman Special Psychiatric Clinic.

Accounting and payment functions. The accounting department is charged with ensuring fiscal accountability within the center and among community service providers. In a typical month this department:

- inputs approximately 4,300 initiations, changes, or terminations to POS authorizations;
- adds about 166 new vendor records to the system;
- prints an average of 4,600 invoice forms for POS;
- prints an average of 2,400 checks, about 95% of which are to community providers and families for services delivered to clients;
- makes payments for more than 350 family voucher users.

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Information technology support. One manager and three staff members support all mainframe and personal computer activities of the center. The center's mid-range mainframe computer handles client and financial data on most regional center activities and generates thousands of checks each month. Staff write and revise programs (250 in 2007) to analyze data and generate reports.

IT staff also support the personal computer use of 200 regional center employees. Their activities include training, technical support, help desk response, and maintenance and replacement of computer equipment and peripherals. In addition, these four individuals manage internal networks such as e-mail, shared files, and internet access; they coordinate disaster preparation efforts related to technology; and they assist staff with proprietary software systems that have been installed for specific projects and to automate center functions.

Human resources (HR) functions. The HR Department manages activities necessary to attract and retain knowledgeable, committed, competent staff able to carry out the complex mission of the regional center. In order to ensure that the center can continue to attract and retain such staff, HR personnel are constantly reviewing benefit programs (health, disability insurance, etc.) to provide maximum value to the center and its employees. In 2007, the HR staff worked with the appropriate units in recruiting 39 new hires, 19 of whom were service coordinators. This required the screening and interviewing of hundreds of applicants. HR staff also administer all aspects of personnel including payroll and performance evaluation.

Coordinating annual giving. The HR Department oversees a range of giving programs that, in 2007, brought the center more than $97,000 in cash and gift donations for clients and families.

Operations management. One manager and 2.5 staff members support the center's reception and mail functions. These include 15,000 pieces of mail sent out each month and hundreds of phone calls per day through the switchboard in addition to the calls routed through the automated call distribution system. This unit has the responsibility for coordinating the cleaning and maintenance of the physical plant including more than 40,000 square feet of floor space; they coordinate the ordering of office supplies and are responsible for maintenance, repair and replacement of office equipment; and they manage more than 3,000 boxes of records stored off-site. Finally, they coordinate overall disaster preparations, including the replenishment of supplies.

Insurance. Additional costs to the center's operating budget are incurred by items such as liability insurance and workers' compensation insurance. With no additional funds coming from the state, costs of such coverage have affected the regional center in the same way they have affected service providers. At the same time, interest earnings, used by centers to fund part of their operating budgets, are down dramatically. In 2006-2007, Lanterman had about $710,000 in interest earnings. For 2207-2008, that figure will be about $600,000, a loss of $110,000 in real dollars. This amount would support the hiring of two service coordinators.

Whether referred to as operations or regional center direct services, the activities described in this document are of direct and obvious benefit to clients and families and are value added to the service delivery system as a whole.

July 22, 2014

Santi Rogers, Director

Department of Developmental Disabilities

1600 Ninth Street

Sacramento, CA 95814

Dear Director Rogers,

This letter is a formal request by the undersigned organization of service providers to the Department of Developmental Services to take all steps necessary to immediately provide a ten percent (10%) increase in the rates provided for vendors utilized to provide services mandated by the Lanterman Act (Welfare and Institutions Code 4500). We are requesting this immediate increase as an interim step pending collection and analysis of the economic data necessary to determine the adequacy of the rates currently paid to vendors.

The request is directed to you as the Director of the Department of Developmental Services, DDS, not only because we understand and believe that it is this Department that has the ability to make the adjustments a reality but also because, with your leadership, we believe we can work together in a cooperative manner with a mutual appreciation for our responsibilities to Californians with developmental disabilities.

Included with this letter is a twenty-seven (27) year historical record of vendor rate adjustments compared to the Consumer Price Index. As you can see from that record, there is no question but that there is a need for an immediate adjustment to prevent the economic collapse of the service provider community. No private, public or nonprofit enterprise could continue to function within a price controlled structure for 27 years.

As we believe you are aware, over the course of the past several administrations, the Department failed to establish any process for collecting, analyzing and reporting cost data on labor and operational expenses necessary to provide mandated services. As a result, there has been no information to enable past administrations and legislatures to have current and accurate data as to the challenges faced by service providers. The consequence, of course, has been no significant change in the rate structure at any time during the past twenty-seven (27) years. We, your community of service providing organizations, continue to cut and stretch spending as much as we can to hold the system together, but we cannot prevent the inevitable erosion in the quality, continuity and accessibility of services that the Lanterman Act promises. There is no doubt that the safety-net for Californians with developmental disabilities is disintegrating despite our best efforts due to neglect of its community-based service providers.

We would ask that you consider the following when reviewing our request:

1. The Department of Developmental Services has, for more than 20 years, failed to establish and conduct any process for collecting and evaluating economic data relative to the actual costs to provide the services and supports required under current law.

2. The Department had in place a practice of not adjusting rates of reimbursement from year to year resulting in a situation in which there was no way to maintain an economically sound relationship between the actual costs to provide services and funds received for the costs.

3. In addition to failing to collect and assess actual cost data in order to determine rate adequacy, the Department further failed to apply any alternative mechanism such as index-based rate adjustments to the rates being paid.

4. The Department also failed to establish any mechanism by which individual vendors were able to provide economic data to support a need for a rate adjustment.

5. Since the Department does not currently have a mechanism for accepting and assessing individual vendor cost data and adjusting individual rates based upon actual cost data, the Department has no means of aggregating such individual costs and rate adjustment data into a State-wide data base for the purposes of understanding changes in vendor costs and implementing uniform rate adjustments to its vendors.

6. The end result of this situation is that as you take over the Department, there is a wall of what can only be described as one of "ignorance and silence" as to the actual and reasonable expenses involved in providing services for the developmentally disabled in California.

In the absence of activity from the Department to collect and understand economic data relative to increases in costs to provide services, the Department has not incorporated funding for rate adjustments in the Department's annual Budget request to the Legislature. This "wall of ignorance and silence" has effectively meant that there is no accurate information to form a basis for sound recommendations and appropriate legislative oversight as to the needs of the developmentally disabled in California. Without such information, it is impossible for even the most sympathetic legislator to intelligently and in an informed manner consider the needs that exist for rate adjustments for those serving the developmentally disabled.

The "wall of ignorance and silence" that predates your appointment has resulted, as we believe you are aware, of a situation in which the rates paid are dramatically less than the actual costs the vendors are incurring. The mainstays of the service delivery systems are nonprofit agencies who now struggle on a day to day basis to keep the doors open. They have raised every dime they can, they have closed every program they can, they have cut every expense they can cut. They can do no more without an immediate increase in the current rates. The gap between rates and expenses has now grown so large that it can no longer be filled with fundraising and cost cutting.

This current year's mandatory adjustments to accommodate California's minimum wage increase is not rate relief but instead only substantiates how far below adequate the current rate structure has fallen.

The fact that DDS reported to the Legislature that rate adjustments were required by law so that many of your vendors could elevate critical direct support staff wage levels to California's Minimum wage is alarming. Please recognize that the tens of thousands of adults who now receive independent living skills instruction, behavior support/crisis intervention, counseling and guidance, employment preparation and support, and so forth in open community settings possess the same diagnostic classifications, disabling conditions and complexities as individuals who were receiving services in the Department's Developmental Centers.

The level of professionalism and expertise necessary to serve these individuals successfully in open community settings requires a skilled and stable workforce at least equal to the personnel employed in the Developmental Centers. Yet the rate structure is so old and inadequate that your community based vendors are unable to pay wages to attract and retain qualified professionals and instead must hire from the minimum wage labor pool. Please contrast this with the compensation levels of your most junior Developmental Center direct support professionals whose wages are established well above the State's minimum wage.

Additionally, each and everyone of the adults now served by community service vendors was taught and supervised by credentialed special educators supported by a cadre of stable and trained paraprofessionals until age 22. None of these public education personnel will have their wages adjusted to accommodate a $10.00 per hour State minimum wage because the compensation level necessary to assure qualified and effective personnel to serve, educate and support individuals with developmental disabilities is well beyond the State's minimum wage. In fact the State's largest School District, LAUSD has recently established a minimum wage for any employment with the District of $15.00 per hour. The vocational and life skills training needs of young adults with developmental disabilities did not evaporate upon their twenty-second birthday, nor did their needs for qualified instructional and support staff. Yet the rate structure is so low that DDS had to make adjustments to "boost" wages for adult instructional staff to $9.00 per hour.

And, of course, all of the above is only heightened by the impact of the State's rate reduction and subsequent rate restoration activities since 2007. When rates were arbitrarily reduced in 2007, the rates in place were already at least ten years out of date. The 2007 rate reduction caused almost all vendors to utilize whatever cash reserves they had available to maintain even minimal programming consistent with the requirements of state law. Necessary upkeep and maintenance of facilities was put off, the community workforce received wage reductions below their already low pay levels and, at the same time, were required to take on steep increases in benefits costs. There is no dispute but that the 2007 rate reductions removed tens of millions of dollars from an already stretched infrastructure.

The State's restoration to 2007 rate levels did not reverse the lost cash reserves nor provide any wage and benefit relief from the already too low pre-2007 levels. The restoration to 2007 rate levels did not address any of the economic realities of cost pressures that were present for the decade before 2007 or any that exist subsequent to that time.

Returning vendors to 2007 rate levels did not mean returning to rates that were determined to be economically viable in 2007 but rather to the same rates that had been imposed and unaltered for up to ten years only now with greatly weakened infrastructures and far less emergency "rainy day" reserves.

While the Department did not require, request or even permit data regarding the impact to vendors and consumers resulting from a failure to provide adequate rates, this does not mean the impacts have not taken place. Chronically high turnover of the most qualified staff as well as numerous and prolonged staff position vacancies have caused significant setbacks to the developmentally disabled of California and pose clear and immediate risks to the health and safety of the population we all strive to serve.

Vendors who once required degreed and professionally qualified personnel now hire from within the pool of applicants who will work for $9.00 per hour. Vendors who regional centers depend upon to increase capacities to serve clients aging into adulthood are not expanding due to lack of capital and rates that can not cover actual costs to provide services.

The community based system for providing services for the developmentally disabled in California is comprised of vendors for whom the Department must establish and regulate rates of reimbursement. It is an unstable system in imminent danger of total collapse without an immediate infusion of funds.

The fact that the Department has, at least historically, seemed to be indifferent to the solvency of the community based system of services is of great concern. While we understand there may be a belief that since there are not wide spread closures, things must not be that bad. That belief is both unfounded and a further example of the "wall of ignorance and silence." California must not wait for human catastrophes before it acts to repair the damage that has been done.

Working together, we can collect real and credible data as to the current financial viability of the community based service delivery system. This data can enable us all to work with facts, not anecdotal or other unreliable information. It will enable us, together, to address the issues central to the preservation of a viable, safe, and effective community based program of services for individuals with developmental disabilities. It is only through the gathering of such data that we can all have the information necessary to make informed and intelligent decisions as to the efficacy and costs of any community based service delivery system.

We look forward to your immediate response to the two requests of this letter. Of utmost importance is an immediate ten percent (10%) increase since we cannot comply with continuously escalating business and employer cost pressures including Affordable Care Act and other public mandates without such an increase. Second, and of equal importance, is the need to develop a working relationship by which accurate and current economic data can be obtained as to the real costs for delivering an effective community based service system for California's developmentally disabled.

We look forward to hearing from you over the course of the next two weeks.

Sincerely,

Cynthia Sewell, President/CEO
New Horizons

Kelly White, CEO
Villa Esperanza

Scott Bowling, President/CEO
ECF

Ronald S. Cohen, Ph.D., President/CEO
UCP

Lori Gangemi, President/CEO
Ability First

Caron Nunez, Executive Director
Lincoln Training Center

Debra Donavan, Executive Director
Valley Village

Cyndi McAuley, Executive Director
Therapeutic Living Centers for the Blind

David A. Bernstein, Executive Director
Hope House

Rebecca Lienhard, Executive Director
Tierra del Sol

Ken Lane, Executive Director
TASC (The Adult Skills Center

Jeff Strully
Jay Nolan Community Services

Bill Young, CEO
CLIMB

Cindy Burton, President/CEO
Pathpoint

Kevin MacDonald, CEO
The Arc—Los Angeles & Orange Counties

Patricia Swisher Schulz, CEO
The Arc—Ventura County

Steve Miller
(Former ED of Tierra del Sol)
Emeritus Coalition Member